NHS

Wirral Clinical Commissioning Group

Governing Body Board Meeting

Tuesday 2nd October 2012
1.00pm – 3.00pm
Nightingale Meeting Room, Old Market House

AGENDA

Ref No	Time	No	Item		Papers
	1300	**1.**	**PRELIMINARY BUSINESS**		
GB12-13/043			**1.1**	**Apologies for Absence** (Chair)	
GB12-13/044			**1.2**	**Declarations of Interest** (All)	
GB12-13/045			**1.3**	**Comments/questions from members of the public**	
GB12-13/046			**1.4**	**Minutes and Action Points of the Last Meeting dated 4th September 2012** (Chair) • Matters Arising	FINAL minutes from GBB Meeting 04 09 2(
	13.45	**2.**	**ITEMS FOR APPROVAL**		
GB12-13/047			**2.1**	**Independent Mental Health Contract** (Chief Operating Officer)	ISHMcoversheet.doc ISHM.doc
GB12-13/048			**2.2**	**Dementia shared Care Model** (Acting Chief Officer WGPCC)	Dementia Shared Care cover sheet 2.1 Dementia Shared Care scheme Governi Dementia Shared Care scheme Governi

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GB12-13/049			**2.3**	**Governance and Audit Committee** (Lay Advisor WCCG)	Audit Governance Committee Front She Establish Audit Governance Committe
	14.00	**3.**	**ITEMS FOR INFORMATION**		
GB12-13/050			**3.1**	**CCG Report** (Designate Clinical Chief Officer)	(v)
GB12-13/051			**3.2**	**Finance and Performance report** (Chief Finance Officer)	GB Finance Update M5 Cover Sheet 20th GB Wirral CCG Finance Report- Mont Copy of GB Wirral CCG Finance Appendi
GB12-13/052			**3.3**	**Quality Report** • Q2 Serious Incident report • Quality Accounts (Chief Operating Officer)	SUIcover sheet.doc SERIOUS INCIDENTS SUMMARY REPORT.d
GB12-13/053			**3.4**	**Minutes for Noting** • Wirral GP Commissioning Consortium • Wirral Health Commissioning Consortium • Wirral Alliance Commissioning Consortium • Performance, Finance and Quality Committee	WGPCC Mins 14 8 12 final.doc WHCC - Executive Board Minutes 09081

					WACC Executive Board Meeting - DRAF WACC Executive Board Meeting - DRAF 13.2DRAFT Minutes QPF - 24th July 2012
	14.10	**5.**	**RISK REGISTER**		
GB12-13/054			**5.1**	**Items to be included onto the Risk Register** (All)	(Master & Gov Body) Risk Register for Gov
GB12-13/055	**1415**	**6.**	**ANY OTHER BUSINESS**		
GB12-13/056	**14.15**	**7.**	**DATE AND TIME OF NEXT MEETING**		
			Tuesday 6th November 2012, 1.00pm at Nightingale Meeting Room, Old Market House Joanne.Scott@wirral.nhs.uk		
	14.30		**Closed Session**		

Wirral Clinical Commissioning Group

WIRRAL CLINICAL COMMISSIONING GROUP
GOVERNING BODY BOARD MEETING
Minutes of Meeting

Tuesday 4th September 2012 at 1300hrs
Duncan Room, Old Market House

Present:	Dr P Jennings (PJ)	DesignateChair WCCG
	Dr A Mantgani (AM)	Designate Clinical Chief Officer WCCG
	Dr J Oates (JO)	Chair Wirral GP Consortium
	Dr A Ali (AA)	GP Executive Wirral GP Consortium
	Dr P Naylor (PN)	Chair Wirral Health Consortium
	Dr M Green (MG)	Chair Wirral Alliance Consortium
	Lorna Quigley (LQ)	Chief Operating Officer WCCG
	Mark Bakewell (MB)	Interim Chief Finance Officer WCCG
	James Kay (JK)	NEA Vice Chair CWW PCT Cluster
	Christine Campbell (CC)	Chief Officer Wirral GP Consortium (Acting)
	Iain Stewart (IS)	Chief Officer Wirral Alliance Consortium
	Fiona Johnstone (FJ)	Director of Public Health
	Steve Rowley (SR)	Principle Manager Adult Social Services (for G Hodkinson)

In Attendance:

Allison Hayes (AJH)	Secretary
Helen Jones (HJ)	Project Manager

4 members of the public attended the meeting

Ref No.	Minute
GB12-13/029	**Preliminary Business** **029.1 Apologies for absence** Apologies were received from Dr Sue Wells, Andrew Cooper and Graham Hodkinson. WCCG Chair welcomed the members of the general public to the meeting. The public members were provided with an overview of the agenda and the format of the meeting.
GB12-13/030	**030.1 Declarations of interest** There were no declarations of interest.

Signed

Ref No.	Minute
GB12-13/031	**031.1 Comments/questions from members of the public** A member of the public sought clarification around the appointments of the Lay Member Representatives and WCCG Chair provided an update regarding the appointments.
GB12-13/032	**032.1 Minutes and Action Points from the previous meeting** Members raised the following points regarding the minutes of the last meeting held on 7th August 2012**:** Page 1 of 4 Declarations of Interests Page 2 of 4 Typing error – the use of the word 'where' instead of 'were'. Page 4 of 4 Clarification regarding the detailed figures to be provided at the next Governing Body. There were no matters arising or action points discussed.
GB12-13/033	**Items for Approval** **033.1 NHS Wirral Policy Adoptions** Helen Jones presented the following polices: Whistle Blowing, Loan Worker, Smoke Free policy and Dignity at Work policy. These were discussed by members and it was agreed that various sentences and paragraphs are reworded to reflect CCG protocols and requirements within each policy to establish the transition from NHS Wirral to Wirral CCG. Members agreed that a glossary of words and references is to be established.
GB12-13/034	**034.1 Memory Assessment Service** CC presented the Memory Assessment Service proposal and the Board were asked to approve the payment of additional funds to CWP to reflect the increase on activity undertaken by the MAS, and to note an increase in prescribing costs due to shared cared protocol changes. A discussion took place around the projections and the joint commissioning aspects of the service. The Governing Body agreed to the proposal.
GB12-13/035	**Items for Information** **035.1 CCG Update** WCCG Accountable Officer updated the group regarding the on-going projects and appointments of the CCG and fed back to the group the results of the recent SHA review.
GB12-13/036	**036.1 Authorisation Plan** LQ provided the group with information around the key steps that are required in order to complete the authorisation process. Discussions took place regarding the 360 Stakeholder Survey that members are required to undertake.
GB12-13/037	**037.1 Finance Update**

Signed

Ref No.	Minute
GB12-13/038	MB updated the group around the financial position and activity for NHS Wirral CCG as at the end of July (month 4) within the 2012/13 financial year. The Board were asked to note: the financial position as at the end of July 2012, the requirement for the CCG to develop, agree and implement spending plans and the potential risks identified for 2012/13 financial performance and contingency reserves held to mitigate performance issues. **038.1 Minutes for Noting** **Wirral GP Commissioning Consortium – July 2012** **Wirral Health Commissioning Consortium – July 2012 –** PN explained the financial activity detailed in the minutes. **Wirral Alliance Commissioning Consortium – June 2012 –** Minutes of the meeting were submitted to the Board but due to technical difficulties these will now be included in the agenda for the next Governing Body meeting along with the minutes for July 2012. **Quality, Performance and Finance Minutes – July 2012**
GB12-13/039	**Risk Register** MB provided an overview of the risk register and the individual risks identified.
GB12-13/040	**Any Other Business** WCCG Accountable Officer gave a presentation regarding the initiatives and investments currently being undertaken within the CCG. A discussion took place regarding the Patient Transport Services and members were advised that a review of the current contract will take place in April 2013.
	Date and Time of Next Meeting The date and time of the next meeting is Tuesday 2nd October 2012 at 1300hrs in the Nightingale Room, Old Market House. Please send any apologies to Lorna Quigley Interim Chief Operating Officer.

The meeting closed at 14.38pm

Signed

Wirral Clinical Commissioning Group

Independent Sector Mental Health (IHSM)

Agenda Item:	2.1	**Reference:**	GB12-13/47
Report to:	Governing Body	**Meeting Date:**	3rd October 2012.
Lead Officer:	Lorna Quigley – Chief Operating Officer		
Contributors:	Melissa Gaselee Contracting Manager (CWW- CSU)		
Governance:	**Link to Commissioning Strategy**		
	Link to current governing body Objectives		

Summary:

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The NHS funded provision of Out of Area Placements for Mental Health services presents challenges to public sector commissioning organisations including the need to meet rising levels of expenditure with more robust controls. The requirements of the NHS specifically in relation to a substantial number of independent and third sector providers requires integrated commissioning arrangements that are able to deliver the quality services required but with the expectation that the costs associated with this service type offer appropriate cost and clinical effectiveness with transparent pricing outlined from the start.

- The contract is currently hosted by NHS North Lancashire and expires on the 31/01/13.
- The contract has 12 Associate PCT's/CCG's of which Wirral is one.
- There are 13 providers that provide the intensive rehab service, ie up to 2 years intensive rehab for adults with mental health needs. Six of the 13 providers in addition provide slower stream services.

This shared arrangement aims to :

- mitigate commissioning risk, for services of unknown quality and at prices that could not evidence value for money
- Seek to improve the commissioning and contracting arrangements and relationships with the mental health independent sector
- ensure that service users access mental health care which is a quality service at a reasonable cost.
- improve the business environment through which commissioners and providers can plan more effectively for the future.

Recommendation:	**To Approve**		x
	To Note		
	Comments		
Next Steps:	The governing body is asked to approve the extension of this contract arrangement for a further 12 months until 31st March 2014.		

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	This proposal is for a block funding which has been accounted for in the CCG Commissioning budget
Value For Money	Working collaboratively with other PCT/CCG's gives better value for money rather than commissioning this as an individual CCG.
Risk	Approving this paper will allow the CCG to enter a pooling arrangement with other CCG's at a fixed cost.
Legal	Assessed, there are no legal implications identified with this proposal.
Workforce	Assessed, no workforce issues have been identified.
Equality & Human Rights	
Patient and Public Involvement (PPI)	
Partnership Working	By approving this paper the CCG will be entering a partnership arrangement with 11 organisations. The impact for these organisations if Wirral CCG does not enter this agreement, the cost to commissioning the service for associates will increase.
Performance Indicators	
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Title of Report	Agenda Ref	Title of Meeting	Date	Detail of outcome and next step

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.

INDEPENDENT SECTOR MENTAL HEALTH (ISMH)

CONTRACT EXTENSION PROPOSAL 2013-14

1.0 Background

1.1 The NHS funded provision of Out of Area Placements for Mental Health services presents various challenges to public sector commissioning organisations including Primary Care Trusts (PCTs) and Local Authorities across all regions.
1.2 Organisations often need to meet rising levels of expenditure with more robust controls. The requirements of the NHS specifically in relation to a substantial number of independent and third sector providers requires integrated commissioning arrangements that are able to deliver the quality services required but with the expectation that the costs associated with this service type offer appropriate cost and clinical effectiveness with transparent pricing outlined from the start.

2.0 Current Position

2.1The contract is currently hosted by NHS North Lancashire.
2.2 The contract has 12 Associate PCT's namely: BwD, BPCT, Bolton, CLPCT, ELPCT, HMR PCT, H&STH, Knowsley, Liverpool, Sefton, Warrington, Wirral.
2.3 There are 13 providers that provide the intensive rehab service, six of the 13 providers in addition provide slower stream services.
2.4 The current contract commenced on 01/04/10 and expires on 31/03/13.
2.5 The contract seeks to prevent:

- spiralling costs associated with increasing levels of spot purchased
- a lack of NHS standard contractual agreements;
- shortfalls in quality assurance;
- pricing structures that were not transparent,
- perceived longer than necessary length of stays,
- inconsistent performance management regimes and
- challenges to demonstrate effective governance

3.0 Benefits

3.0 The contract mitigates commissioning risk, for services of unknown quality and at prices that could not evidence value for money. It had become apparent that different PCT's were being charged varying prices for the same services with an initial basic price and then further add on costs being charged frequently as the placement progressed.
3.1 The contract also seeks to improve the commissioning and contracting arrangements and relationships with the mental health independent sector.
3.2 The contract will ensure that service users access mental health care which is a quality service at a reasonable cost.
3.3 The contract improve the business environment through which commissioners and providers can plan more effectively for the future.

4.0 Recommendation

4.1 To continue with a ‘steady state’ of contract arrangements ie extend the current contract for a further 12 months until 31st March 2014.

Wirral Clinical Commissioning Group

Memory Assessment Service Capacity Review – CWP

Agenda Item:	2.2	**Reference:**	GB12/13/048
Report to:	Governing Body	**Meeting Date:**	2nd October 2012
Lead Officer:	Christine Campbell – Chief Officer (Acting) WGPCC		
Contributors:	Barbara Edwards, Programme Manager – CWWCSU Chris Harwood, Business Intelligence - CWWCSU David Miles, Finance - CWWCSU		
Governance:	**Link to Commissioning Strategy**	Commissioning of Mental Health Services remains a key element of CCG Commissioning Strategy	
	Link to current governing body Objectives	Review of capacity / demand for memory assessment services	
Summary:	This paper sets out recommendations for a revised pathway for the Memory Assessment Service provided by Cheshire and Wirral Partnership Trust, and the development of a Local Enhanced Service to support the proposed shared care arrangements with primary care.		
Recommendation:	**To Approve**		✓
	To Note		
	Comments		
Next Steps:	Following approval of the arrangements and the LES, the provider will begin to discharge patients as per the timescales set out within the paper, practices will be notified of the pathway change, and the LES and shared care arrangements will be launched.		

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What are the implications for the following (please state if not applicable):	
Financial	A total potential resource of £127,380 will be required to support the implementation of the LES across 61 practices in 2012/13
Value For Money	It is more cost-effective for patients that no longer require consultant intervention to be discharged into and managed by primary care.
Risk	The pathway has been designed to minimse risk to patients, by only discharging those that the MAS has deemed appropriate for shared care. An option to fast-track patients back into the MAS is available should patients require more intensive intervention, and consultant advice will be available through advice and e-mail.
Legal	N / a
Workforce	The resource available through the LES will support the additional time required to undertake patient reviews.
Equality & Human Rights	The pathway will apply equally to all Wirral patients identified as suitable for shared care.
Patient and Public Involvement (PPI)	A stakeholder event has been arranged to launch the shared care arrangements.
Partnership Working	The revised pathway and shared care arrangement have been developed and agreed by a group comprising multi-agency representation, including Wirral DASS, CWP, voluntary sector and Wirral CCG / GPs.
Performance Indicators	The shared care arrangement and pathway will be monitored through the Dementia Strategy Group.
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

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Wirral Clinical Commissioning Group

Wirral CCG

Local Enhanced Service

Shared Care Arrangements for people diagnosed with Dementia

Background

1. In the last two years, the Department of Health (DoH) has released various publications linked to the work streams around Dementia Care. The refresh of the national Strategy (Quality outcomes for people with dementia: building on the work of the National Dementia Strategy DH 2010)[1] centred on a revised, outcomes focused implementation plan for 'Living Well with Dementia – A National Dementia Strategy' The National Dementia strategy was published in February 2009, and refreshed via an Implementation Plan in September 2010.

2. Dementia care is a key priority area in the Operating Framework [2] which includes the requirement that 'commissioners should work with GP practices to secure ongoing improvements in the quality of general practice and community services so that patients only go into hospital if that will secure the best clinical outcome'.

3. In March 2011, NICE issued technology appraisal guidance 217, specifically requiring the use of a range of medications for people with mild to moderate Alzheimer's disease. This guidance replaces NICE technology appraisal guidance 111 issued in November 2006.

4. The review and re-appraisal of donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease has resulted in the following changes:

   - donepezil, galantamine and rivastigmine are now recommended as options for managing mild as well as moderate Alzheimer's disease, **and**

   - memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChE inhibitors, and as an option for managing severe Alzheimer's disease.

Local Context

5. As a consequence of the national strategy, Wirral PCT and Department of Adult Social Services developed a local strategy for Older People with Mental Health Needs[3]. The local strategy built on the development and implementation of a locally agreed dementia pathway. Both the pathway and local strategy identified the need for people to receive care and treatment in the community for as long as possible and reduce the need for unplanned hospital admissions.

6. In implementing the local strategy, NHS Wirral has developed and commissioned a Wirral-wide Memory Assessment Service, together with a range of community-based support services and initiatives.

[1] Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy (DoH 2010)
[2] The Operating Framework for the NHS in England 2012/13 (DoH 2011)
[3] NHS Wirral and Wirral Department of Adult Social Services: A Strategy for Services for Older People with Mental Health Needs 2009 and Beyond (unpublished 2009) Wirral Older People

7. The Memory Assessment Service (MAS) commenced in October 2010 and is provided by Cheshire & Wirral Partnership NHS Trust (CWP). This followed the decommissioning of the former community Memory Clinic.

8. The referrals and caseload within the service have continued to increase, which has placed pressure on capacity within and therefore access to the service. NHS Wirral and latterly Wirral CCG have agreed to commission additional capacity to ensure continued access, however it is recognised that the service in its current form is insufficient to meet local current and predicted demand. Therefore alternative models of delivery, including shared care arrangements for monitoring and review with Primary Care are being developed.

Rationale

9. Dementia is a medical disorder and should be managed like any other serious long-term illness, including regular monitoring, conducting health checks (for the person with dementia and their carers), ensuring people with dementia attend screening programs, advising on preventive actions, advanced decision making and contingency planning, and signposting people to local information, advice & support services.

10. GPs have a crucial role in ensuring that early concerns about memory problems are detected and responded to, and not misattributed to the symptoms of old age and also that the early signs of young onset dementia (people under 65) are addressed.

11. Following national and local awareness-raising campaigns, people are encouraged to express concerns about their memory at an earlier stage to ensure people get the right support as early as possible. It is envisaged that this will increase the demand on GP practices. It is also recognised that assessing people and making a dementia diagnosis at an earlier stage could be more challenging.

12. The GP practice has an important role to play in following the person with dementia and their carers through the different stages of dementia to ensure all support is available for the patient's ongoing management of health and well-being, and also to ensure that any carer needs are identified and addressed.

Aims

13. This GP Local Enhanced Service for Dementia Care in 12/13 aims to:

- increase GP and Practice Nurse knowledge and understanding of the management of patients with dementia, and also of the needs of carers and the support that is available;

- increase the early recognition and diagnosis of dementia through opportunistic screening (asking patients if they have problems with their memory affecting their daily life when they routinely attend GP/Practice Nurse appointments) and work towards the estimated prevalence for their practice on their dementia register. Practices should use the CANTABMobile App on the iPad as the preferred assessment option; however, *there are several assessment tools available in addition to the* ***Mini Mental State Examination, such as (6-CIT), GPCOG, The 7 Minute Test, Confusion Assessment Method;***

- provide a recall and review system for people who have been transferred back into primary care from the MAS after being initiated and stabilised on Anti Cholinesterase (ACIs) according to the local shared care protocol, or those for whom medication is not appropriate but a six-monthly review has been deemed appropriate by the MAS;

- share the management of patients with dementia and to clarify the role of primary and secondary care, and other stakeholders as appropriate in assessment, diagnosis, medication (initiation, maintenance and decision making around discontinuation of medication), follow on care and end of life care;

- implement regular medication reviews for patients stable on dementia medication, to be undertaken within primary care. This proposed way of working meets NICE guidance as long as it is part of a shared care protocol and structures are in place for fast track referrals back to the Wirral Memory Assessment service in case of any doubts, side effects or deterioration for which the GPs require specialist input from secondary care;

- contribute towards the reduction of the waiting time for a memory assessment in the MAS, by implementing the shared care protocol in the GP practices. This will enable the MAS to focus on the increasing demand and more complex cases.

- provide care closer to home and reduce the number of stable patients being managed in secondary care;

- provide a holistic package of care to enable more people with dementia and their carers to be managed in primary care where appropriate;

- enhance physical care and health promotion advice for all patients and carers for people with dementia, especially regarding vascular dementia;

- ensure patients with dementia and their carers receive the same level of dementia care among all GP practices in Wirral;

- provide support for patients and carers, via the Dementia Carers Outreach service provided by Alzheimer's Society, Wirral Branch. WIRED for the Carer Break Programme.

Requirements

14. To qualify for payment under this LES, the practice will be required to:

Identification / Assessment

15. undertake investigations/screening as indicated in the Shared Care Protocol (Appendix 2) and investigate any abnormalities to exclude potentially treatable causes prior to referral to Wirral Memory Assessment Service;

16. undertake opportunistic screening especially regarding high risk groups (people with learning disabilities, people who have had a stroke or have a neurological condition such as Parkinson's disease);

17. maintain accurate and up-to-date dementia registers: ensure all patients with dementia are registered on the practice dementia register and their carers on the carers register. The practice will signpost carers to available support as appropriate;

Shared Care

18. record the discharge letter received from Wirral Memory Assessment Service and act upon guidance mentioned in the letter;

19. adopt the Shared Care Model including the management of people stable on dementia medication (acetyl-cholinesterase / memantine). See Appendix 1 proposed delivery model;

20. undertake a bi-annual review of all patients discharged from the MAS into a shared care arrangement from 1st December 2012 onwards. This review must be in line with the protocol in Appendix Two. It is recommended that one review per year is carried out by a GP, and the follow-up review by a nurse. However, it is up to each practice to determine the most appropriate clinical solution according to their workforce. The reviews must be face-to-face;

21. have a system in place to ensure all patients on Anti Cholinesterase (ACIs) / memantine treatment and anti-psychotics are reviewed in line with current guidelines;

22. continue the prescribing of AChE inhibitor / memantine treatment and adjust the dose as advised by the Memory Assessment Service and in line with NICE clinical guidelines;

23. notify Wirral Memory Assessment dementia nurse of any adverse drug reactions, deterioration in condition or any other clinical concerns regarding the patient's health that can not be managed in Primary Care;

24. a small minority of patients will be discharged into shared care without being on medication, and a six-monthly review schedule has been recommended. In these cases, the GP will need to determine if a six-monthly review remains appropriate (through face-to-face review of the patient), or if the patient can be stepped down from shared care.

Training and Education

25. identify a named clinical lead for Dementia, who will be responsible for cascading any relevant information to colleagues in the practice;

26. The Clinical Lead for Dementia will attend one annual educational training course (option to attend training delivered by members of the Wirral Memory Assessment Service, or complete a e-learning module, such as modules available from http://e-lfh.org.uk/projects/dementia/index.html or http://www.scie.org.uk/publications/elearning/dementia/index.asp

27. commit to allow its clinical staff to participate in a programme of professional development to ensure that GPs and practice staff develop expertise and knowledge to manage patients with dementia, and provide carers with essential support information. To support this, it is proposed that the CCG will:

- commission Wirral Memory Assessment Service to provide 4 training sessions per annum for GP's;

- commission Wirral Alzheimer's Society provide Dementia Awareness training sessions for non clinical staff;

- Promote free E-learning training available for GPs via http://e-lfh.org.uk/projects/dementia/index.html with a range of modules available from http://www.scie.org.uk/publications/elearning/dementia/index.asp for clinical and non clinical staff.

Validation and Payment

28. Payments under this LES will be paid as follows:

28.1 One off payment of £500 per practice to support training and education for lead Dementia clinician

28.2 Each practice will receive a one-off, upfront payment of £1000, irrespective of list size, to reflect the administrative efforts required to set up a call and recall system.

A practice will be expected to offer one GP review appointment and a follow-up nurse appointment to each patient discharged into shared care within a twelve-month period. The practice will be expected to submit monthly returns detailing the number of nurse and GP review appointments carried out under this LES in respect of patients discharged into shared care. **The number of appointments claimed for will not exceed one nurse and one GP appointment per patient per annum.** Practices will be expected to submit a monthly return to receive reimbursement for reviews undertaken. £20 will be paid per

nurse appointment, and £40 per GP appointment. This will be validated by data received from CWP, detailing the number of patients discharged into a shared care arrangement.

29. Practices must make use of the Read Code and free text in Appendix Three to record each review undertaken under Shared Care Arrangements. Practices will be selected at random to monitor performance under this LES and to verify payments.

30. Payment is only for patients discharged from Wirral Memory Assessment Service to the practice during 2012/13.

Monitoring and PPV

31. The practice will be subject to routine Post Payment Verification process in respect of delivery of this service.

Significant Events

32. The provider will:

- Supply the CCG with full details of all serious significant events occurring within services covered by this service level agreement, including details of actions taken to remedy these situations.
- Notify the CCG within one working day of any significant event/ incident affecting patients, staff or premises giving rise to concern to the Clinical Chief Officer, Wirral CCG

Complaints

33. The provider must comply with the Wirral CCG complaints procedure and notify the CCG as appropriate of any comments:

Complaints - CCG Office
Old Market House
Hamilton Street
Birkenhead
CH41 5FL

Termination/ Cancellation Period

34. Either party can provide 1 month's written notice to exit the scheme.

34. The CCG may terminate the scheme within 28 days if, following the suspension of payments, the contractor fails to re-establish services according to the service specification or take appropriate action to address deficiencies within eligibility criteria.

Agreement and Signatories

This agreement is based on current information and is subject to review in light of guidance subsequently received.

The scheme is effective from 1 November 2012 and will run until 31 March 2013 at which point it will be reviewed.

This scheme is a Local Enhanced Service.

We the undersigned wish to participate in the Dementia Shared Care Local Enhanced Service in accordance with the terms and conditions laid out in this document.

Senior Partner **Date**

Practice Name

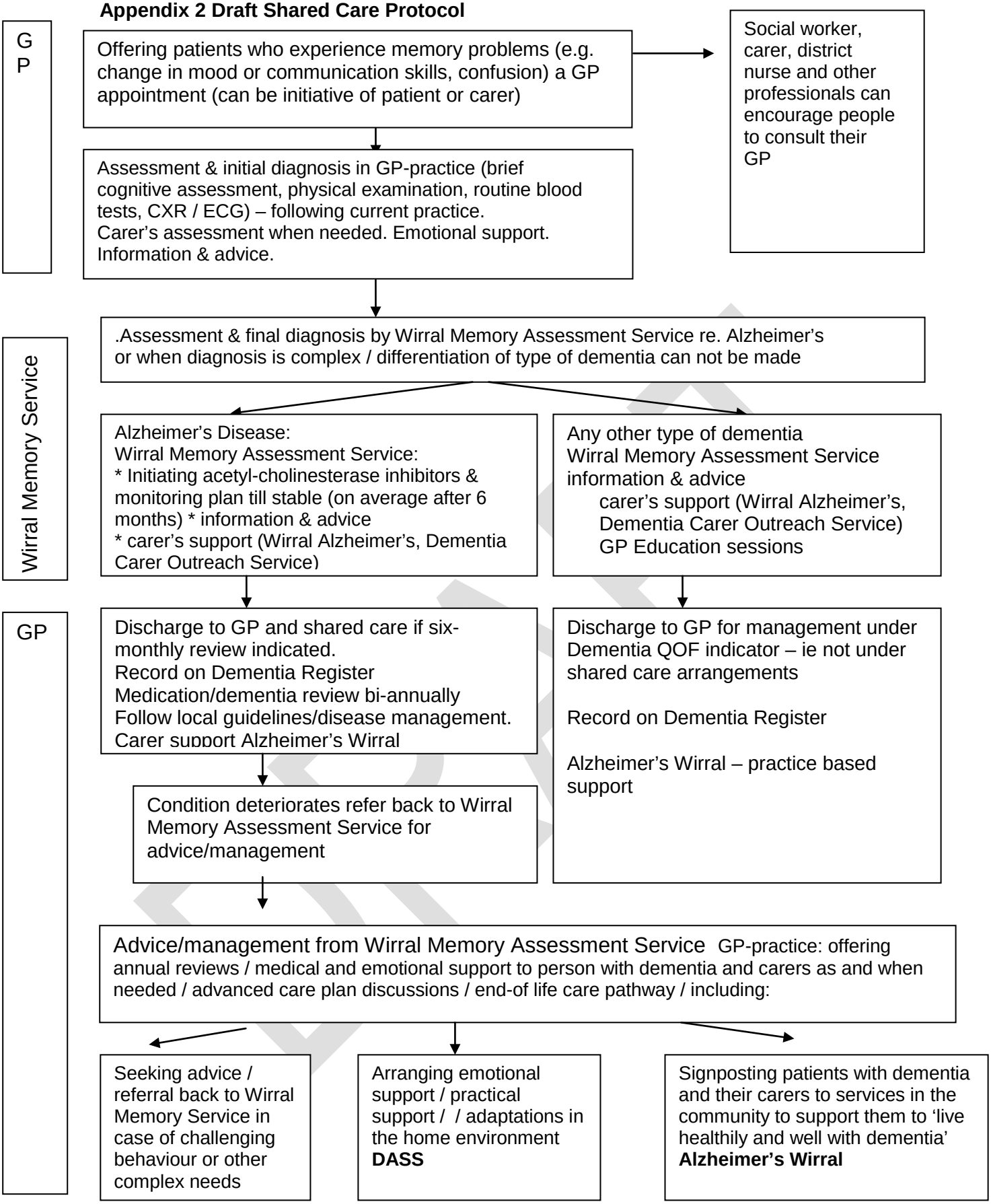
Deputy Director of Primary Care **Date**

Subsequent agreements will be negotiated between the NCB and Practice as part of the annual process of reviewing and agreeing services.

Appendix 1 – Proposed Shared Care Model

	WMAS Role	Primary Care Role	Advantages	Disadvantages/ Risks	Resource Implications
Shared Care "B"	Diagnosis Initiation of treatment Stabilisation	Ongoing prescribing Ongoing support Ongoing monitoring Medical care	Reduction in potential drug interactions/drugs being omitted from primary care prescribing record Drug initiation problems reduced Provides a period of time to assess situation fully and identify additional problems	Potential loss of consistency of approach Inequalities of support for people on medication c/w people not on drug treatments	Drug budgets after stabilisation with primary care Primary Care staff will need to take over monitoring (30 mins every 6/12 –training and resource issues) Expected increase in referrals back to CMHTs/WMAS (implications for PbR) Need to increase resources for support in primary care Need to increase WMAS staffing in lines with capacity modelling (assessment and ongoing monitoring) Less need to increase non-medical prescribing staff in WMAS

Appendix 2 Draft Shared Care Protocol



Appendix Three

The practice MUST use this Read Code against any patients that are managed in accordance with this LES:

66SY.	Shared care: other agency / GP

This must be accompanied by the free text: **Shared Care with MAS**,

along with the date that notification of discharge from MAS into shared care arrangements was received.

All patients managed under this LES should also be on the Practice Dementia QOF Register

	WMAS Role	Primary Care Role	Advantages	Disadvantages/ Risks	Resource Implications
Current Model	Diagnosis Initiation of treatment Stabilisation Ongoing prescribing Ongoing support Ongoing monitoring	Ongoing support Medical care	Specialist Diagnosis Seamless CMHT referral when problems Centralised coordination and planning Opportunity for emergency care planning, life story work Efficiencies of scale	Service not funded to meet current demand, so likely to be increasing waiting times until capacity needs met	Need to increase WMAS staffing in lines with capacity modelling (assessment and ongoing monitoring) Need to increase non-medical prescribing staff in WMAS

Shared Care "A"	Diagnosis Initiation of treatment	Stabilisation Ongoing prescribing Ongoing support Ongoing monitoring Medical care	Reduction in potential drug interactions/drugs being omitted from primary care prescribing record	Most problems with drug treatment occur early in treatment, so would be need to re-refer if problems/side-effects Difficulties in ensuring optimal treatment if titration responsibility of 66 GP practices Potential loss of opportunities of whole system planning to reduce admissions Potential loss of consistency of approach Inequalities of support for people on medication c/w people not on drug treatments	Need to increase WMAS staffing in lines with capacity modelling (assessment only) Less need to increase non-medical prescribing staff in WMAS Primary Care staff will need to take over monitoring (30 mins every 6/12 –training and resource issues) Expected increase in referrals back to CMHTs/WMAS (PbR implications)

Shared Care "B"	Diagnosis Initiation of treatment Stabilisation	Ongoing prescribing Ongoing support Ongoing monitoring Medical care	Reduction in potential drug interactions/drugs being omitted from primary care prescribing record Drug initiation problems reduced Provides a period of time to assess situation fully and identify additional problems	Potential loss of consistency of approach Inequalities of support for people on medication c/w people not on drug treatments	Drug budgets after stabilisation with primary care Primary Care staff will need to take over monitoring (30 mins every 6/12 –training and resource issues) Expected increase in referrals back to CMHTs/WMAS (implications for PbR) Need to increase resources for support in primary care Need to increase WMAS staffing in lines with capacity modelling (assessment and ongoing monitoring) Less need to increase non-medical prescribing staff in WMAS

Shared Care "C"	Diagnosis Initiation of treatment Stabilisation Ongoing support Ongoing monitoring	Ongoing prescribing Medical care	Reduction in potential drug interactions/drugs being omitted from primary care prescribing record Provides ongoing specialist support and signposting to people with dementia and their carers		Drug budgets after stabilisation with primary care No need for Primary Care staff to take over monitoring Expected increase in referrals back to CMHTs/WMAS (implications for PbR) Need to increase resources for support in primary care Need to increase WMAS staffing in lines with capacity modelling (assessment and ongoing monitoring) Less need to increase non-medical prescribing staff in WMAS

NHS

Wirral Clinical Commissioning Group

Dementia Shared Care Model

Introduction

1. A paper was brought to the September meeting of the Governing Body Board outlining pressure within the Memory Assessment Service provided by Cheshire and Wirral Partnership Trust. The paper sought Board approval for investment to support additional capacity within this service before the end of the financial year. It was outlined within this paper that this was a short-term solution, and that a shared care model was under development that would address capacity issues in the longer term.

2. This paper sets out further detail of this shared care model, and seeks the Board's approval for a local enhanced service that will support the delivery of this model within primary care.

Background

3. It is one of the commissioning intentions within the contract with Cheshire and Wirral Partnership Trust that during 2012/13 commissioners and providers would work together to review and revise the existing pathway between the Memory Assessment Service (MAS) and primary care. This was on the basis that the service did not have sufficient capacity to manage the existing and projected number of referrals, and that there was greater scope for primary care management of dementia patients. This is supported by the recommendations of the National Dementia Strategy[1]. A task and finish group was established six months ago to take this forward, chaired by Dr Peter Arthur. This group has comprised representatives from the CCG, DASS, WUTH, CWP, Commissioning Support Unit and Wirral Alzheimer's Society.

4. The average waiting time for an initial assessment with the MAS is 12 weeks from referral to first assessment (as at September 2012). Patients are not currently discharged from the service, and so the caseload and waiting time continue to grow. It was clear that an alternative to the current model was necessary to ensure continued access and quality of care for patients with suspected and confirmed dementia.

5. Furthermore, the strategic context to a shared care model is set out within sections 1 – 12 of the proposed Local Enhanced Service, within Appendix One.

Proposed Pathway and Model

6. The task and finish group developed three alternative pathway options, which are outlined within Appendix Two. Through consultation with primary care colleagues, it was agreed that option 'B' would be most appropriate to both providers and commissioners. The proposed patient pathway under this model is on page 8 of the LES (Appendix One).

[1] http://www.dh.gov.uk/health/2011/07/dementia-strategy/

7. Key points to note are:

- the MAS will assess, diagnose, prescribe, stabilise, and discharge into primary care with a management plan once the patient is in a stable position and does not require further consultant support / intervention;

- the MAS will continue to refer the patient into the Wirral Alzheimer's Society and signpost to other agencies as it does currently. The support provided by these agencies would continue once the patient is discharged to GP care;

- The shared care arrangement will apply to all patients that:

- are discharged from the MAS having been prescribed medication for their dementia
- are discharged from the MAS with no medication, but with a recommended six-monthly review schedule. For these patients, the GP Practice will need to determine if a six-monthly review remains appropriate, or if these patients are to be stepped down from the shared care arrangement (this may only be done following at least one face-to-face review with the patient, by a GP);

- Any patients not in either of the above categories will either:

- Remain under the care of the MAS as they are not yet stable / suitable for discharge
- Be discharged into GP Practice care with a diagnosis of dementia, but not require any follow-up above and beyond the requirements of QOF (ie an annual review)
- Be discharged into GP Practice care with no diagnosis of dementia;

- The discharge information from CWP will detail the management plan and the scope of the review to be undertaken with the patient, and will make it very clear who is and is not appropriate for shared care.

Timescale

8. The following timescales have been proposed by of the task and finish group:

- 18th October – stakeholder event to further explain the shared care model and give the opportunity for any further adjustments to the model or enhanced service

- 1st November – launch of enhanced service. CWP will notify practices of the patients being discharged into the shared care arrangements, and will discharge those with a review date of December 2012

- 1st December - CWP discharge remaining patients into GP Practice care, prioritising according to next review date.

9. The provider and commissioner leads met on 20th September to discuss any operational issues necessary to ensure a smooth transition between the MAS and primary care. The following was agreed:

- Following agreement by this Board, a letter will be issued to all practices explaining the revised pathway and the LES. It will be made clear that the shared care arrangements

and pathway will be put into place, irrespective of whether or not practices choose to sign up to the LES. If a practice does not sign up to the LES, the CCG will seek to commission this from a neighbouring practices in order that there is equity of access

- Any patients whose follow-up with the MAS is due in December 2012 will be prioritised: they will receive a letter in early November 2012 to explain the new arrangements and that their next follow-up will be with their GP (it will be stressed that it will be the responsibility of the practice to contact the patient, and NOT the responsibility of the patient to contact their practice).

- A letter will concurrently go to those patients' GP to ask that these patients are called for review under the shared care arrangement as soon as possible

- Following this first tranche of patients, the remaining patients will be contacted on a staged basis (ie starting with those whose review is due first). Each practice will be issued with the list of all patients being discharged into the shared care arrangement and it will be recommended that they prioritise the invitations to patients according to the next review date.

Practice Responsibilities

10. The requirements of the shared care scheme for practices are listed in points 15 – 26 of the enclosed LES document. Key requirements are:

    - ensure all patients with dementia are accurately coded and included on the practice QOF register
    - identify named clinical lead for dementia who complies with specific training requirements in the LES and supports practice colleagues
    - follow the revised dementia pathway for all new patients with potential dementia identified from 1st November 2012 onwards
    - undertake a twice-yearly review of all patients discharged from the memory assessment service from 1st November 2012 onwards, where it is specified that those patients require a bi-annual review
    - take on the ongoing prescribing responsibility for any patients with medication started under the MAS, and review this medication as part of the bi-annual review
    - ensure all patients managed under this shared care arrangement are coded appropriately on the practice clinical system
    - seek advice / support from the MAS as and when required, and refer any patients back into the MAS should their condition deteriorate or their needs become more complex
    - actively identify any carers and carer needs, ensuring the practice carer register is updated, and signposting to WIRED and other sources of carer support

Ongoing Role of Wirral MAS

11. Under the revised pathway, the Wirral MAS will:

- assess, diagnose, treat and stabilise any Wirral patient referred into its service;

- refer the patient to the Wirral Alzheimer's Society upon acceptance into the service;
- discharge patients back to their GP, advising if a patient is appropriate for shared care or not. All patients will be discharged with an ongoing management plan and discharge summary;
- provide telephone and e-mail support to the patient's practice in relation to patients discharged into the shared care arrangement;
- offer fast-track appointments for any patient under the shared care arrangement that requires further MAS intervention, due to a worsening of condition / increased complexity;
- offer annual educational events to support the revised pathway.

Training and Education

12. It is recognised that practices will need significant support to manage patients within primary care. The clinical lead must undertake either a face-to-face training session (to be provided by MAS) or a specified e-learning module on an annual basis.

13. The Wirral Alzheimer's Society will offer training for non-clinical staff, and the practice must support its staff to attend these sessions.

Prescribing

14. Practices will take on responsibility for prescribing and managing any medication initiated under the MAS. As any drugs issued will be Amber Drugs, the budget for these drugs will be managed centrally by the CCG, and therefore individual practices will not bear the financial responsibility for this element.

15. Work is ongoing with CWP to determine the likely financial impact with regard to prescribing. It is anticipated that the additional drugs costs will be largely offset by the fact that the two most commonly used prescribed are due to come off patent imminently, and costs will significantly reduced.

Resource Implications of the LES

16. The change in pathway will not immediately require any additional investment into the contract with CWP for the MAS other than what has already been agreed by this Board.

17. Costings for 2012/13 have been based upon the patients that CWP advises will be discharged into shared care and whose follow-up appointment is due before end of March 2012/13.

18. The payments applicable under the LES in 2012/13 will be:

    £60 per patient per year (£40 for an initial GP appointment, and £20 for a follow-up nurse appointment within a twelve-month period)

    £1000 per practice as a start-up cost (one-off payment)
    £500 per year for training

19. **2012/13**

598 patients are due to be discharged into shared care during 2012/13.

For ease of calculating payments, these have been based on the fact that practices will receive £60 per year in respect of each patient discharged in that financial year under the shared care arrangement. So, the payments due during 2012/13 are as follows:

61 x £1500	£91,500
598 x £60	£35,880
Total	**£127,380**

This resource has been set aside in Wirral CCG reserves.

20. **2013/14**

The CCG is only able to commit funds until the end of 2012/13; however, it is the intention to continue the revised pathway, the shared care arrangement, and therefore the Local Enhanced Service, into 2013/14 (the LES will be contingent upon there being available funding).

Based on modelling undertaken on behalf of the CCG, it is forecast that a further 500 – 600 patients will be discharged during 2013/14, bringing the total under shared care to a potential 1198.

The total resource required in 2013/14, if the LES were to be recommissioned, is therefore estimated to be:

Reviews:	1198 x £60	£71,880
Training:	61 x £500	£30,500
Total:		£102,380

Other Resource Implications

21. Any training to be provided under the LES during 2012/13 has already been accounted for through non-recurrent resources made available by the Local Authority to Wirral Alzheimer's Society.

Monitoring Implementation of the Pathway and Shared Care Scheme

22. The Dementia Task and Finish Group is due to become the Dementia Strategy Group, which will comprise similar representation, but take forward the recommendations of the Wirral Dementia report produced by Peter Lacey in early 2012. This Group will monitor the shared care arrangements and will determine and implement any necessary modifications.

23. A progress report will be brought to the March meeting of the Governing Body in order to compare primary care caseload against projected figures, and raise any additional resource implications for continuing arrangements beyond 2013/14.

Conclusion

24. An amendment to the existing Memory Assessment Service pathway is vital to ensure that waiting times do not continue to rise, and that the service has sufficient capacity to assess and manage those patients who are at most need of specialist intervention.

25. Discharge into primary care once patients are stable is in line with national guidance, and has been supported through consultation with the Wirral GP community. The LES provides a framework to support GP Practices to undertake this element of the pathway.

26. GPs will be expected to review and manage the medical aspects of the patient's condition. Agencies such as WIRED, Wirral DASS and the Wirral Alzheimer's Society will continue to play a vital role in ensuring that patients and their families / carers receive appropriate social support within the community and are able to live their lives to as full an extent as possible.

Recommendation

27. The Governing Body is asked to:

- support the implementation of shared care model 'B'
- approve the Dementia Shared Care Local Enhanced Service
- approve the total potential resource requirement to deliver this LES of **£127,380** during 2012/13

Christine Campbell
Chief Officer - WGPCC (Acting)

September 2012

Wirral Clinical Commissioning Group

Establishment of Audit and Governance Committee

Agenda Item:	2.3	**Reference:**	GB12-13/049
Report to:	Governing Body	**Meeting Date:**	2nd September 2012
Lead Officer:	Mark Bakewell		
Contributors:	Lorna Quigley		
Governance:	**Link to Commissioning Strategy**	N/A	
	Link to current governing body Objectives	To ensure robust structures are in place for good governance and to ensure the CCG is compliant with its audit requirements	
Summary:	In order to fulfill the functions that the governing body is responsible for exercising. Processes and systems need to be developed to comply with the regulations and directions as outlined in the draft constitution.		
Recommendation:	**To Approve**	✔	
	To Note		
	Comments		
Next Steps:	Audit Committee to establish Terms of Reference, Liaison with Internal / External Audit providers, develop a schedule of assurance requirements		

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	N/A
Value For Money	N/A
Risk	If an Audit committee is not approved the governing body will not fulfill their

	statuary obligation with regard to ensuring there is a robust governance structure within the CCG.
Legal	N/A
Workforce	N/A
Equality & Human Rights	N/A
Patient and Public Involvement (PPI)	The establishment of the audit committee will ensure that there is patient/public involvement in the decision making processes at the Governing body
Partnership Working	Once fully established the audit committee will demonstrate partnership working with the Lay Advisors , Mersey Internal Audit Agency, Grant Thornton (External Audit) and member practices
Performance Indicators	N/A
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	Yes

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.

NHS Wirral Clinical Commissioning Group

Establishment of Audit & Governance Committee

Introduction

1. NHS Wirral Clinical Commissioning Group has previously established an Audit & Governance Working Group with the purpose of ensuring the relevant work streams were progressing and pending appointments made to a number of CCG posts in order to fully establish the committee.

2. The working groups remit has been defined as per below

    a. Provide assurances to the CCG Governing Body on matters relating to Integrated Governance, Risk Management and Internal Control.
    b. Ensuring that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the CCG.
    c. Review the work and findings of the external auditors and consider the implications and management's responses to their work.

3. The Audit & Governance working group has in effect been working in shadow form since approval at Governing Body meeting in May 2012

Establishment of Audit & Governance Committee

4. Given that a number of recent appointments have been made to the relevant posts within the CCG structure, including those of the lay members for Audit & Governance and Patient Champion. This provides the ideal opportunity for the CCG to formally begin the process of establishing its formal audit committee within the CCG organisational structure in line with recommended best practice and in order to further strengthen the assurance process to the governing body.

Next Steps

5. Once the remit to formally establish the CCG Audit & Governance Committee has been approved by the Governing Body. A process led by the Lay Advisor (Governance & Audit) to establish a new Terms of Reference, further development of the membership of the committee, producing a schedule of assurance requirements by the committee, receiving internal / audit reports as appropriate to feed back to the Governing Body on its level of assurance

Mark Bakewell
Chief Financial Officer (Designate)
NHS Wirral Clinical Commissioning Group
26th September 2012

Wirral Clinical Commissioning Group

NHS Wirral – Financial Position Month 5

Agenda Item:	3.2	**Reference:**	GB12-13/051
Report to:	Governing Body	**Meeting Date:**	2nd October 2012
Lead Officer:	Mark Bakewell –Chief Financial Officer (Designate)		
Contributors:			
Governance:	**Link to Commissioning Strategy**	Sound financial control is essential to the CCG strategy and is directly linked to the delivery of the CCG Commissioning and Operational Plan for the financial year.	
	Link to current governing body Objectives	To achieve financial control total with sound financial management.	
Summary:	This report updates the CCG on financial position as at the end of August (M5) within the 2012-13 financial year		
Recommendation:	**To Approve**		
	To Note		✓
	Comments		
Next Steps:	Continued monitoring of financial position throughout the financial year		

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	The report identifies the relevant financial position of the CCG as at the end of August within the 2012/13 financial year
Value For Money	All expenditure plans are subject to an ongoing value for money review
Risk	Keys risks identified with regards to financial performance of CCG
Legal	Legal advice is sought on financial issues as and when required.
Workforce	N/a
Equality & Human Rights	Financial Plans will consider as appropriate the equality impact assessment for proposals within the budgeted expenditure
Patient and Public Involvement (PPI)	Budgets include funding to ensure continued involvement of patients and public in CCG decisions.
Partnership Working	The CCG works with a number of NHS Trusts and the Local Authority within a number of its commissioning budgets.
Performance Indicators	The plan reflects the planned achievement of statutory financial duties within the overall PCT position

Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
M5 Finance Report		Quality, Performance and Finance	25th September 2012	Noted with appropriate Risks

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of "prejudicial" is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.

NHS Wirral Clinical Commissioning Group

Finance Report for the period 1st April 2012 to 31st August 2012

Introduction

1. This report sets out the financial position for NHS Wirral Clinical Commissioning Group (Wirral CCG) as at the end of August (Month 5) within the 2012/13 financial year.

Resources

2. The total budget allocated to Wirral CCG for the year is £468 million from within the overall PCT baseline of £660m. Based on the federated model approach a number of budgets have now been aligned to the newly formed Governing Body (£136m) to be managed on an economy wide basis and the remaining budgets devolved to the combined consortia (£332m). This is usually where practice level information is available and performance is based on actual activity (using GP Registration for individual patients).

3. As in the previous financial year the budgets are split according to "commissioning" expenditure or "running costs" expenditure.

4. Commissioning Expenditure Budgets are split across a number of categories based on "planned" levels of expenditure in 2012/13. The table below illustrates how these budgets are assigned:

Commissioning Expenditure	Governing Body	Combined Consortia
NHS Contracts	✓	✓
Non NHS Contracts	✓	✓
Prescribing	✓	✓
Commissioned Out of Hospital	✓	
Intermediate, Social Care and Reablement	✓	
Other Commissioning Expenditure		✓
Reserves	✓	
Running costs	✓	✓

5. Running Costs are split between those of the core teams (including Clinical Backfill) which report under the individual consortia and the Commissioning Support Unit (CSU) which reports under the Governing Body but within the 12/13 financial year do not reflect the SLA offer that is currently being negotiated.

Financial performance

6. As at the end of August (Month 5) the year to date position for Wirral CCG is an over spend of £1.6m with over performance against commissioning expenditure of £1.870m offset by an under performance against running costs of £0.271m

7. This compares to the July Month 4 position of £1.1m overspent with the adverse movement of £455k being mainly due an increased over performance on the Wirral University Teaching Hospitals FT (WUTH) contract being offset by further under spends in other commissioning areas and the partial release of contingency reserves at Governing Body level.

8. The year to date variance position between Governing Body and the combined consortia is an overspend at divisional level of £2.4m with the Governing Body underspent by £0.846m.

9. A year to date overall Financial Summary for Wirral CCG is available in Appendix 1. The table below shows the performance variances at month 5:

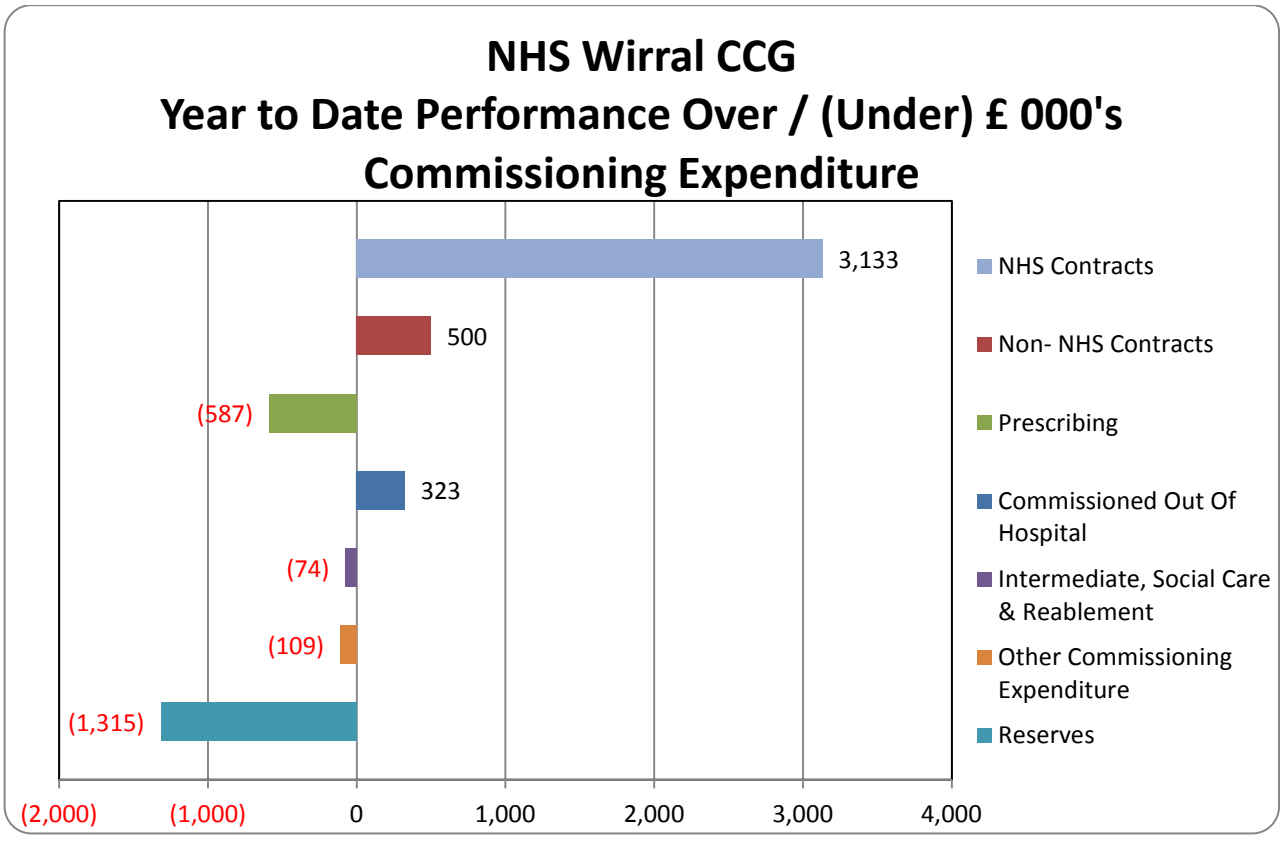
YTD variance	Combined Consortia £ 000	Governing Body £ 000	Total Wirral CCG £000
Commissioning Expenditure	2,661	(791)	1,870
Running costs	(216)	(55)	(271)
TOTAL	**2,445**	**(846)**	**1,599**

10. Appendix 2 shows the Divisonal Financial Summary including a summary for each of the consortia. The performance variance year to date for the consortia is shown in the table below:

	Consortia Budgets		
	Commissioning £000	Running Costs £ 000	**Total £ 000**
WGPCC	(186)	(113)	**(299)**
WHCC	2,846	(75)	**2,771**
WHA	24	(28)	**(4)**
Total	**2,661**	**(216)**	**2,445**

11. Narrative regarding financial performance is reported on an exception basis according to variation against planned levels of expenditure. More detailed information is included in Appendices 3 to 6.

12. Year to date variance from budget for the CCG is analysed below:



NHS Contracts

13. The overall CCG performance position in relation to NHS contracts shows an overspend at month 5 of £3.133m primarily being due to over performance on the Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) contract of £2.85m at divisional level.

14. The year to date position is based on actual activity as at Month 4 (as per below) with a pro-rata adjustment to equate to month 5 position and application of estimated contract adjustments for re-admissions / outpatient follow-up ratios as appropriate (again based on the month 4 actual activity position).

WUTH Point of Delivery	YTD Performance as at July 2012 Over / (Under)
Elective	£164k
Non-Elective	£1,552k
Non-Elective (Non-Emergency)	(£274k)
Outpatient Attendances	£243k
Outpatient Procedures	£249k
A&E	(£22k)
PbR Total	**£1,912k**
Non-PbR Total	£280k
POD Total	**£2,192k**

15. The point of delivery above shows over performance across all the areas at differential rates with the exception of non-elective non-emergency. The most significant financial pressure is focused on the non-elective performance at the provide, however there are signs that the elective over performance is beginning to increase to a material level

16. Further work is being currently being undertaken to investigate the underlying causes and divisional / practice reviews are being conducted to review at a detailed level.

17. Performance at Governing Body level budgets on other NHS contracts shows a combined overspend of £71k with over performance on the North West Ambulance Service £115k, Aintree £52k and Liverpool Women's £40k contracts, being offset by underperformance on the Clatterbridge Cancer Centre (CCC) contract of £111k.

18. Contract performance will need to be closely monitored over the coming months alongside other performance information including referral information, conversion rates, RTT targets etc. to enable an accurate forecast position for the remainder of the year.

Non-NHS Contracts

19. At month 5 Non NHS Contracts are over spent by £500k. The year to date over performance is due to a number of factors as outlined below

20. Firstly the backlog of patients transferring to "Spire" due to 18 week RTT targets from earlier in the financial year (£175k)

21. Over performance against planned levels of activity also exist against the "Spire" contract for patient choice referrals (non RTT Backlog patients) £93k, Spa Medica (Ophthalmology) £127k and Independent Midwifery One to One provider £92k for ante / post natal care.

Prescribing

22. Prescribing expenditure is currently providing the CCG with a year to date underspend of £587k. There is an over performance of those budgets managed at Governing Body level of £169k due in the main to Amber Drugs which is being offset by underperformance at divisional level of £757k. Performance position is based on three month's actual data with two months forecast costs for July and August.

23. Further data is still required in order to make an accurate assessment of potential levels of expenditure and there remain a number of planning assumptions which have still yet to tested against actual expenditure incurred.

Commissioned Out of Hospital

24. Commissioned "out of hospital" budgets are £323k overspent at month 5, which shows an adverse movement in month of £66k. The main drivers for the over performance exist under the Continuing Healthcare section with Older People (£135k) and Physical Disabilities (£62k), and all Joint Funded packages (£224k) being offset by underperformance on Funded Registered Nursing Care (FRNC) and other packages of care.

Reserves

25. Reserves are underspent by £1,315k at Month 5 which is due to the release of the contingency element on a year to date basis to offset areas of over performance as described earlier within the performance report.

26. Detailed plans are still required against a number of areas of planned expenditure that are still being held in reserve until approval through the various CCG committees.

Running Costs

27. There is an underspend of £271k in relation to running costs at month 5 mainly due to clinical backfill reported at consortia level. A review with the individual consortia leads is on-going to ensure all approved expenditure is being captured within the reporting position.

Forecast Outturn

28. Although a number of commissioning budgets are over performing as at the end of August 2012 the CCG remains on target to achieve a balanced position against its allocation.

29. One of the key performance drivers to the financial performance position remains around the WUTH contract and as such given the current intelligence regarding contract performance has been extended within the forecast outturn position to the value of £4.8m.

30. Provided that the WUTH position remains in line with the forecast position described above and a steady state with the other current performance position (Non-NHS category etc.), the CCG would still be in a position to achieve a balanced position.

31. Management of the year end position given the current assumptions would be set out as per the below:

NHS Wirral Clinical Commissioning Group		
Financial Summary - 2012/13 Forecast Outturn		
Month 5	**Annual Budget**	**Forecast Variance**
Clinical Commissioning Groups(CCG)	£'000	£'000
NHS Contracts	328,116	5,343
Non-NHS Contracts	12,440	1,185
Prescribing	59,760	(897)
Commissioned Out of Hospital	29,290	541
Intermediate, Social Care & Reablement	8,847	(132)
Other Commissioning Expenditure	9,680	61
Reserves	10,049	(5,414)
Total CCG Commissioning Expenditure	**458,181**	**686**
Running Costs	**9,853**	(686)
Overall CCG	**468,034**	**0**

32. It should be noted that the performance position however does restrict the ability to support new additional commissioning investments and as such the relative value in the contingency and other reserve has been released to offset the contract over performance

Financial Risk

33. The CCG's Financial Plans identified the main areas of financial risk in terms of performance for the year and an overall CCG Risk with regards to financial performance.

Original Risk Identified	Potential Risk Value	Degree of Forecast Risk	Current Forecast Performance	Degree of Forecast Risk
Packages of Care	£1.0 million		£0.5m	
Performance on Secondary Care Contracts (WUTH)	£3.0 million		£5.3m	
Prescribing	£1.2 million		(£0.9m)	
Cost Efficiencies	£6.2 million		Linked to other risks as embedded within contracts but managed via contingency	
Overall CCG Risk			Break Even	

Degree of Forecast Risk – Assessed as

Red Over performance > 2%
Amber Over performance > 1%
Green Minimal Risk (Forecast Underperformance or low value)

34. Risks will be subject to constant review as more information becomes available regarding performance against planned levels of expenditure.

Conclusion

35. The Executive Board is asked to note:

- the financial position as at the end of August 2012
- the requirement for the CCG to develop, agree and implement spending plans as soon as possible where not already approved
- the potential risks identified for 2012/13 financial performance and contingency reserves held to mitigate performance issues.

Mark Bakewell
Chief Financial Officer
NHS Wirral Clinical Commissioning Group

20th September 2012

NHS Wirral Clinical Commissioning Group

Financial Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Spend	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)								
NHS Contracts	328,116	134,744	137,878	3,133	2,390	743		5,343
Non-NHS Contracts	12,440	5,035	5,534	500	319	180		1,185
Prescribing	59,760	24,706	24,118	(587)	(353)	(234)		(897)
Commissioned Out of Hospital	29,290	11,980	12,302	323	257	66		541
Intermediate, Social Care & Reablement	8,847	3,630	3,556	(74)	(71)	(4)		(132)
Other Commissioning Expenditure	9,680	2,587	2,478	(109)	19	(128)		61
Reserves	10,049	1,985	670	(1,315)	(1,315)	(0)		(5,414)
Cost Improvement Programme	0	0	0	0	0	0		0
Total CCG Commissioning Expenditure	**458,181**	**184,666**	**186,537**	**1,870**	**1,246**	**624**	**0**	**686**
Running Costs	**9,853**	**4,081**	**3,810**	(271)	**(102)**	(169)		(686)
Overall CCG	**468,034**	**188,748**	**190,347**	**1,599**	**1,144**	**455**	**0**	**0**

NHS Wirral Clinical Commissioning Group

Governing Body Financial Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Spend	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)								
NHS Contracts	66,585	27,526	27,597	71	78	(7)		265
Non-NHS Contracts	3,816	1,590	1,662	72	16	56		173
Prescribing	9,478	3,949	4,119	169	103	67		539
Commissioned Out of Hospital	29,290	11,980	12,302	323	257	66		541
Intermediate, Social Care & Reablement	8,847	3,630	3,556	(74)	(71)	(4)		(132)
Other Commissioning Expenditure	88	37	0	(37)	(29)	(7)		(88)
Reserves	10,049	1,985	670	(1,315)	(1,315)	(0)		(5,414)
Cost Improvement Programme	0	0	0	0	0	0		0
Total CCG Commissioning Expenditure	**128,153**	**50,696**	**49,905**	**(791)**	**(961)**	**170**	**0**	**(4,117)**
Running Costs	**8,074**	**3,340**	**3,285**	(55)	**63**	(118)		(255)
Total Governing Body CCG	**136,227**	**54,036**	**53,190**	**(846)**	**(898)**	**52**	**0**	**(4,372)**

NHS Wirral Clinical Commissioning Group

Divisional Financial Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Spend	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)								
NHS Contracts	261,531	107,219	110,281	3,062	2,312	750		5,078
Non-NHS Contracts	8,624	3,445	3,873	428	303	124		1,012
Prescribing	50,282	20,756	20,000	(757)	(456)	(301)		(1,436)
Commissioned Out of Hospital	0	0	0	0	0	0		0
Intermediate, Social Care & Reablement	0	0	0	0	0	0		0
Other Commissioning Expenditure	9,591	2,550	2,478	(72)	48	(120)		149
Reserves	0	0	0	0	0	0		0
Cost Improvement Programme	0	0	0	0	0	0		0
Total CCG Commissioning Expenditure	**330,028**	**133,970**	**136,631**	**2,661**	**2,208**	**454**	**0**	**4,804**
Running Costs	**1,779**	**741**	**525**	(216)	(165)	(51)		(431)
Total Division CCG	**331,807**	**134,711**	**137,157**	**2,445**	**2,043**	**403**	**0**	**4,372**

NHS Wirral Clinical Commissioning Group

Divisional Financial Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	261,531	107,219	110,281	3,062	2,312	750	5,078
Non-NHS Contracts	8,624	3,445	3,873	428	303	124	1,012
Prescribing	50,282	20,756	20,000	(757)	(456)	(301)	(1,436)
Commissioned Out of Hospital	0	0	0	0	0	0	0
Intermediate, Social Care & Reablement	0	0	0	0	0	0	0
Other Commissioning Expenditure	9,591	2,550	2,478	(72)	48	(120)	149
Reserves	0	0	0	0	0	0	0
Cost Improvement Programme	0	0	0	0	0	0	0
Total Division CCG Commissioning Expenditure	**330,028**	**133,970**	**136,631**	**2,661**	**2,208**	**454**	**4,804**
Running Costs	**1,779**	**741**	**525**	(216)	**(165)**	(51)	(431)
Total Division for CCG	**331,807**	**134,711**	**137,157**	**2,445**	**2,043**	**403**	**4,372**

NHS Wirral Clinical Commissioning Group

Wirral Health Commissioning Consortium Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	125,988	51,702	54,497	2,795	2,023	772	4,706
Non-NHS Contracts	3,183	1,315	1,606	290	125	165	642
Prescribing	24,103	9,950	9,881	(69)	39	(108)	(131)
Commissioned Out of Hospital	0	0	0	0	0	0	0
Intermediate, Social Care & Reablement	0	0	0	0	0	0	0
Other Commissioning Expenditure	2,242	862	692	(170)	(49)	(121)	(171)
Reserves	0	0	0	0	0	0	0
Cost Improvement Programme	0	0	0	0	0	0	0
Total CCG Commissioning Expenditure	**155,514**	**63,829**	**66,675**	**2,846**	**2,138**	**708**	**5,046**
Running Costs	**809**	**337**	**262**	(75)	(57)	(18)	(177)
Total Wirral Health CC	**156,323**	**64,166**	**66,937**	**2,771**	**2,081**	**690**	**4,868**

NHS Wirral Clinical Commissioning Group

Wirral GP Commissioning Consortium Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	103,916	42,562	42,559	(3)	177	(180)	(106)
Non-NHS Contracts	4,062	1,558	1,777	220	168	51	578
Prescribing	20,070	8,285	7,724	(561)	(398)	(163)	(1,062)
Commissioned Out of Hospital	0	0	0	0	0	0	0
Intermediate, Social Care & Reablement	0	0	0	0	0	0	0
Other Commissioning Expenditure	6,316	1,467	1,626	159	122	37	386
Reserves	0	0	0	0	0	0	0
Cost Improvement Programme	0	0	0	0	0	0	0
Total CCG Commissioning Expenditure	**134,363**	**53,872**	**53,685**	**(186)**	69	**(255)**	**(203)**
Running Costs	**708**	**295**	**182**	(113)	**(90)**	(23)	(192)
Total Wirral GP CC	**135,072**	**54,167**	**53,868**	**(299)**	**(21)**	**(278)**	**(395)**

NHS Wirral Clinical Commissioning Group

Wirral Alliance Commissioning Consortium Summary - 2012/13

Month 5	Annual Budget	Budget To Date	Spend To Date	Variance	Prior Mth YTD Variance	Change In YTD Variance	Forecast Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Commissioning Groups(CCG)							
NHS Contracts	31,556	12,925	13,213	288	141	147	506
Non-NHS Contracts	1,378	571	490	(82)	10	(92)	(206)
Prescribing	6,096	2,516	2,395	(121)	(93)	(28)	(229)
Commissioned Out of Hospital	0	0	0	0	0	0	0
Intermediate, Social Care & Reablement	0	0	0	0	0	0	0
Other Commissioning Expenditure	1,034	221	161	(61)	(25)	(36)	(66)
Reserves	0	0	0	0	0	0	0
Cost Improvement Programme	0	0	0	0	0	0	0
Total CCG Commissioning Expenditure	**40,064**	**16,234**	**16,258**	**24**	**34**	**(10)**	**4**
Running Costs	**262**	**109**	**81**	(28)	(18)	(10)	(62)
Total Wirral Alliance CC	**40,326**	**16,343**	**16,340**	**(4)**	**16**	**(19)**	**(58)**

GP Commissioning Consortia - 2012/13 Budgets 100.00%

Performance Monitoring	Total Wirral CCG				
Month 5	Annual Budget	Budget to Date	Spend to Date	Variance - Over / (Under)	Forecast Variance
Commissioning Expenditure	£000	£000	£000	£000	£000
a) NHS Contracts	**328,116**	**134,744**	**137,878**	**3,133**	**5,343**
Wirral University Teaching Hospital NHS Foundation Trust	208,138	85,119	87,972	2,854	4,756
Wirral Community NHS Trust	43,916	18,079	18,145	67	0
Cheshire and Wirral Partnership NHS Foundation Trust	33,407	13,864	13,857	(7)	(27)
North West Ambulance Service NHS Trust	10,558	4,348	4,463	115	277
Clatterbridge Centre of Oncology NHS Foundation Trust	8,919	3,674	3,563	(111)	(174)
Royal Liverpool & Broadgreen University Hospital	7,434	3,060	3,065	5	12
Aintree Hospital NHS Fundation Trust	3,085	1,268	1,320	52	52
NonContracted Activity	2,192	913	914	0	91
Countess of Chester NHS Foundation Trust	2,299	946	962	15	37
Liverpool Womens NHS Foundation Trust	2,102	865	905	40	96
WARRINGTON & HALTON HOSPITALS NHS FT	119	49	99	49	119
St Helen'S & Knowsley	706	291	293	3	6
Sth Manchester NHS FT	207	85	84	(1)	(3)
Liverpool PCT	21	9	7	(2)	(5)
Wrightington, Wigan&Leigh FT	191	79	84	5	12
Christie Hospital NHS Foundation Trust	129	53	65	12	22
Central Manchester Uni NHS Foundation Trust	328	136	164	28	68
ISTC - Diagnostics	238	99	100	1	3
Merseycare	48	20	20	0	1
PCMH	1,682	789	796	7	0
Other (CQUIN, IM&T, Advancing Quality etc)	2,395	998	998	0	0
b) Non- NHS Contracts	**12,440**	**5,035**	**5,534**	**500**	**1,185**
Specialist Care (Health Treatment Panel)	2,046	852	917	64	154
Independent Sector	3,932	1,613	2,042	429	717
St Johns Hospice	1,665	694	696	3	6
Royal NI Deaf	25	10	13	2	5
PCMH	1,971	695	695	(0)	0
Independent Midwifery	918	383	475	92	396
Assura- Ophthalmology	208	87	39	(47)	(114)
Other Contracts (E.g Hoylake Cottage, Claire House etc)	1,675	701	658	(42)	21
c) Prescribing	**59,760**	**24,706**	**24,118**	**(587)**	**(897)**
Prescribing	50,282	20,756	20,000	(757)	(1,436)
Other Prescribing	9,478	3,949	4,119	169	539
d) Commissioned Out Of Hospital	**29,290**	**11,980**	**12,302**	**323**	**541**
Continuing Healthcare	12,693	5,289	5,513	224	301
Joint Funding Packages of Care	7,909	3,296	3,520	224	463
FRNC - Funded Registered Nursing Care	5,077	2,128	2,037	(91)	(223)
Childrens	1,486	619	638	19	3
Other Packages (E.g CITC / Joint Finance etc)	2,124	648	594	(53)	(4)
e) Intermediate, Social Care & Reablement	**8,847**	**3,630**	**3,556**	**(74)**	**(132)**
f) Other Commissioning Expenditure	**9,680**	**2,587**	**2,478**	**(109)**	**61**
Consortia Commissioning Fund	856	149	86	(63)	0
Service Development Budgets	1,687	771	699	(72)	(72)
Locally Commissioned Services	1,787	744	849	104	250
PBC Savings	5,351	922	844	(77)	(117)
Practice Transfer Consortium Adjustment	0	0	0	0	0
g) Reserves	**10,049**	**1,985**	**670**	**(1,315)**	**(5,414)**
Earmarked & Other	9,019	1,872	557	(1,315)	(5,414)
Contract Risk Reserve	1,030	113	113	0	0
h) Cost Improvement Programme - unallocated	**0**	**0**	**0**	**0**	**0**
Total Commissioning Budget 12/13	**458,181**	**184,666**	**186,537**	**1,870**	**686**
Total Running Cost Budget 12/13	**9,853**	**4,081**	**3,810**	**(271)**	**(686)**
Grand Total	**468,034**	**188,748**	**190,347**	**1,599**	**0**

GP Commissioning Consortia - 2012/13 Budgets 100.00%

Performance Monitoring	Total Governing Body				
Month 5	Annual Budget	Budget to Date	Spend to Date	Variance - Over / (Under)	Forecast Variance
Commissioning Expenditure	£000	£000	£000	£000	£000
a) NHS Contracts	**66,585**	**27,526**	**27,597**	**71**	**265**
Cheshire and Wirral Partnership NHS Foundation Trust	33,407	13,864	13,857	(7)	(27)
North West Ambulance Service NHS Trust	10,558	4,348	4,463	115	277
Clatterbridge Cancer Centre NHS Foundation Trust	8,919	3,674	3,563	(111)	(174)
Royal Liverpool & Broadgreen University Hospital	7,434	3,060	3,065	5	12
Aintree Hospital NHS Fundation Trust	3,085	1,268	1,320	52	52
NonContracted Activity	197	82	44	(38)	0
Liverpool Womens NHS Foundation Trust	2,102	865	905	40	96
St Helen'S & Knowsley	706	291	293	3	6
Christie Hospital NHS Foundation Trust	129	53	65	12	22
Merseycare	48	20	20	0	1
b) Non- NHS Contracts	**3,816**	**1,590**	**1,662**	**72**	**173**
Specialist Care (Health Treatment Panel)	2,046	852	917	64	154
Independent Sector	80	33	36	3	7
St Johns Hospice	1,665	694	696	3	6
Royal NI Deaf	25	10	13	2	5
c) Prescribing	**9,478**	**3,949**	**4,119**	**169**	**539**
d) Commissioned Out Of Hospital	**29,290**	**11,980**	**12,302**	**323**	**541**
Continuing Healthcare	12,693	5,289	5,513	224	301
Joint Funding Packages of Care	7,909	3,296	3,520	224	463
FRNC - Funded Registered Nursing Care	5,077	2,128	2,037	(91)	(223)
Childrens	1,486	619	638	19	3
Other Packages (E.g CITC / Joint Finance etc)	2,124	648	594	(53)	(4)
e) Intermediate, Social Care & Reablement	**8,847**	**3,630**	**3,556**	**(74)**	**(132)**
f) Other Commissioning Expenditure	**88**	**37**	**0**	**(37)**	**(88)**
Safeguarding Nurse	88	37	0	(37)	(88)
g) Reserves	**10,049**	**1,985**	**670**	**(1,315)**	**(5,414)**
Earmarked & Other	9,019	1,872	557	(1,315)	(5,414)
Contract Risk Reserve	1,030	113	113	0	0
h) Cost Improvement Programme - unallocated	**0**	**0**	**0**	**0**	**0**
Total Commissioning Budget 12/13	**128,153**	**50,696**	**49,905**	**(791)**	**(4,117)**
Total Running Cost Budget 12/13	**8,074**	**3,315**	**3,252**	**(63)**	**(255)**
Grand Total	**136,227**	**54,011**	**53,158**	**(854)**	**(4,372)**

GP Commissioning Consortia - 2012/13 Budgets | **100.00%**

Performance Monitoring	**Total Divisional Consortia**				
Month 5	**Annual Budget**	**Budget to Date**	**Spend to Date**	**Variance - Over / (Under)**	**Forecast Variance**
Commissioning Expenditure	**£000**	**£000**	**£000**	**£000**	**£000**
a) NHS Contracts	**261,531**	**107,219**	**110,281**	**3,062**	**5,078**
Wirral University Teaching Hospital NHS Foundation Trust	208,138	85,119	87,972	2,854	4,756
Wirral Community NHS Trust	43,916	18,079	18,145	67	0
NonContracted Activity	1,995	831	869	38	91
Countess of Chester NHS Foundation Trust	2,299	946	962	15	37
WARRINGTON & HALTON HOSPITALS NHS FT	119	49	99	49	119
Sth Manchester NHS FT	207	85	84	(1)	(3)
Liverpool PCT	21	9	7	(2)	(5)
Wrightington, Wigan&Leigh FT	191	79	84	5	12
Central Manchester Uni NHS Foundation Trust	328	136	164	28	68
ISTC - Diagnostics	238	99	100	1	3
PCMH	1,682	789	796	7	0
Other (CQUIN, IM&T, Advancing Quality etc)	2,395	998	998	0	0
b) Non- NHS Contracts	**8,624**	**3,445**	**3,873**	**428**	**1,012**
IS Reserve	0	0	175	175	175
ISTC	2	1	1	(0)	(1)
ISTC - Cataracts	550	220	347	127	238
Extended Choice Network	96	40	71	31	74
Spire - Standard Acute Contract	3,204	1,318	1,412	93	224
Independent Sector	3,852	1,580	2,005	426	710
PCMH	1,971	695	695	(0)	0
Independent Midwifery	918	383	475	92	396
Assura- Ophthalmology	208	87	39	(47)	(114)
Other Contracts (E.g Hoylake Cottage, Claire House etc)	1,675	701	658	(42)	21
c) Prescribing	**50,282**	**20,756**	**20,000**	**(757)**	**(1,436)**
Prescribing	50,282	20,756	20,000	(757)	(1,436)
d) Commissioned Out Of Hospital	**0**	**0**	**0**	**0**	**0**
e) Intermediate, Social Care & Reablement	**0**	**0**	**0**	**0**	**0**
f) Other Commissioning Expenditure	**9,591**	**2,550**	**2,478**	**(72)**	**149**
Consortia Commissioning Fund	856	149	86	(63)	0
Service Development Budgets	1,687	771	699	(72)	(72)
Locally Commissioned Services	1,787	744	849	104	250
PBC Savings	5,262	885	844	(40)	(29)
g) Reserves	**0**	**0**	**0**	**0**	**0**
h) Cost Improvement Programme - unallocated	**0**	**0**	**0**	**0**	**0**
Total Commissioning Budget 12/13	**330,028**	**133,970**	**136,631**	**2,661**	**4,804**
Running Costs					
i) Core team Costs	894	366	327	(39)	(97)
j) Clinical Backfill	886	375	198	(177)	(334)
Total Running Cost Budget 12/13	**1,779**	**741**	**525**	**(216)**	**(431)**
Grand Total	**331,807**	**134,711**	**137,157**	**2,445**	**4,372**

GP Commissioning Consortia - 2012/13 Budgets
Performance Monitoring

Month 5	47.84% Wirral Health Commissioning Consortium				39.99% Wirral GP Commissioning Consortium				12.14% Wirral Alliance CCG				100% Total Division Combined			
	Annual Budget	Budget to Date	Spend to Date	Variance - Over / (Under)	Annual Budget	Budget to Date	Spend to Date	Variance - Over / (Under)	Annual Budget	Budget to Date	Spend to Date	Variance - Over / (Under)	Annual Budget	Budget to Date	Spend to Date	Variance - Over / (Under)
Commissioning Expenditure	£				£				£				£			
a) NHS Contracts	**125,987,671**	**51,702,255**	**54,496,803**	**2,794,548**	**103,916,381**	**42,562,499**	**42,559,046**	**(3,453)**	**31,556,147**	**12,924,897**	**13,212,665**	**287,768**	**261,531,031**	**107,218,662**	**110,280,931**	**3,062,269**
Wirral University Teaching Hospital NHS Foundation Trust	99,568,449	40,718,740	43,396,496	2,677,756	83,236,710	34,039,838	34,011,709	(28,129)	25,276,379	10,336,832	10,557,399	220,567	208,138,274	85,118,612	87,972,407	2,853,795
Wirral Community NHS Trust	21,008,327	8,648,368	8,680,373	32,005	17,562,431	7,229,818	7,256,573	26,755	5,333,160	2,195,469	2,203,594	8,125	43,915,888	18,078,583	18,145,486	66,903
NCA - RJAH Orthopaedic & Dist H	41,219	17,174	32,607	15,433	34,458	14,357	27,259	12,902	10,464	4,360	8,278	3,918	86,164	35,900	68,162	32,262
NCA - BCU East	42,812	17,836	17,836	0	35,790	14,911	14,911	0	10,868	4,528	4,528	0	89,495	37,285	37,285	0
NCA - BCU Central	57,619	24,007	24,007	0	48,168	20,070	20,070	0	14,627	6,094	6,094	0	120,448	50,185	50,185	0
NCA - BCU West	42,888	17,870	17,870	0	35,853	14,939	14,939	0	10,887	4,536	4,536	0	89,653	37,355	37,355	0
NCAs	671,320	279,716	279,717	0	561,207	233,836	233,836	0	170,421	71,009	71,009	0	1,403,330	584,720	584,721	1
NCA - Uni Hsp Birmingham NHS FT	25,798	10,749	5,600	(5,149)	21,567	8,986	4,682	(4,304)	6,549	2,729	1,422	(1,307)	53,929	22,470	11,707	(10,763)
NCA - Oxford Radcliffe Hsp NHS T	6,262	2,607	3,803	1,196	5,235	2,180	3,179	1,000	1,590	662	965	304	13,090	5,450	7,950	2,500
NCA - Lancashire Tchg Hsp NHS FT	11,205	4,669	7,704	3,035	9,367	3,903	6,440	2,537	2,844	1,185	1,956	770	23,423	9,760	16,104	6,344
NCA - Southport & Ormskirk H	35,318	14,715	19,642	4,927	29,525	12,301	16,420	4,119	8,966	3,736	4,986	1,251	73,828	30,760	41,059	10,299
NCA - Mid Cheshire Hosps NHS FT	20,138	8,391	7,096	(1,295)	16,835	7,014	5,932	(1,083)	5,112	2,130	1,801	(329)	42,097	17,540	14,833	(2,707)
NonContracted Activity	***954,580***	***397,734***	***415,882***	***18,148***	***798,004***	***332,496***	***347,667***	***15,171***	***242,329***	***100,969***	***105,575***	***4,607***	***1,995,457***	***831,425***	***869,361***	***37,936***
Countess of Chester NHS Foundation Trust	1,099,997	452,740	493,356	40,616	919,570	378,479	295,411	(83,068)	279,245	114,932	172,949	58,017	2,299,439	946,410	961,838	15,428
WARRINGTON & HALTON HOSPITALS NHS FT	57,098	23,500	34,838	11,338	47,733	19,646	59,655	40,010	14,495	5,966	4,113	(1,853)	119,358	49,125	98,601	49,476
5th Manchester NHS FT	98,995	40,743	44,880	4,137	82,758	34,060	28,937	(5,124)	25,131	10,343	10,228	(115)	206,940	85,170	84,062	(1,108)
Liverpool PCT - Homeopathy	10,190	4,246	2,995	(1,251)	8,519	3,549	2,344	(1,205)	2,587	1,078	1,478	400	21,302	8,875	6,816	(2,059)
Wrightington, Wigan&Leigh FT	91,560	37,682	44,347	6,666	76,542	31,501	33,009	1,508	23,243	9,566	6,610	(2,956)	191,397	78,770	83,967	5,197
Central Manchester Uni NHS Foundation Trust	157,027	65,108	86,230	21,122	131,270	54,428	62,078	7,650	39,863	16,528	15,995	(533)	328,249	136,101	164,327	28,226
ISTC - Diagnostics	113,711	47,378	24,181	(23,198)	95,059	39,607	62,587	22,980	28,866	12,027	13,538	1,510	237,701	99,040	100,306	1,266
PCMH - WHCC	1,682,026	788,638	795,847	7,209	0	0	0	0	0	0	0	0	1,682,026	788,638	795,847	7,209
Other (CQUIN, IM&T, Advancing Quality etc)	**1,145,712**	**477,378**	**477,378**	**0**	**957,786**	**399,076**	**399,076**	**0**	**290,850**	**121,187**	**121,187**	**0**	**2,395,000**	**997,913**	**997,913**	**0**
b) Non- NHS Contracts	**3,182,504**	**1,315,372**	**1,605,671**	**290,299**	**4,061,594**	**1,557,539**	**1,777,072**	**219,533**	**1,377,908**	**571,419**	**489,743**	**(81,677)**	**8,623,820**	**3,445,080**	**3,872,669**	**427,589**
IS Reserve	0	1	90,287	90,286	0	1	63,341	63,341	0	0	21,027	21,027	0	2	174,656	174,654
ISTC	1,191	495	310	(185)	996	414	260	(154)	302	126	79	(47)	2,490	1,035	649	(386)
ISTC - SpaMedica	263,012	105,383	191,592	86,208	219,872	88,098	111,296	23,198	66,768	26,753	44,444	17,692	549,802	220,294	347,332	127,038
Extended Choice Network	45,926	19,135	29,792	10,657	38,393	15,996	39,542	23,546	11,659	4,858	1,695	(3,163)	96,003	40,000	71,029	31,029
Spire - Standard Acute Contract	1,532,513	630,680	812,466	181,786	1,281,142	527,232	532,989	5,757	389,043	160,104	66,112	(93,992)	3,203,571	1,318,375	1,411,567	93,192
Independent Sector	***1,842,642***	***755,694***	***1,124,448***	***368,754***	***1,540,402***	***631,741***	***747,428***	***115,686***	***467,772***	***191,840***	***133,357***	***(58,483)***	***3,851,866***	***1,579,706***	***2,005,233***	***425,527***
PCMH	0	0	0	0	1,401,101	457,921	457,921	0	570,000	237,500	237,449	(51)	1,971,101	695,421	695,370	(51)
Independent Midwifery	439,150	182,979	157,700	(25,279)	367,118	152,966	279,800	126,834	111,482	46,451	37,100	(9,351)	918,000	382,500	474,600	92,100
Assura- Ophthalmology	99,659	41,523	8,676	(32,848)	83,313	34,712	28,719	(5,993)	25,299	10,541	1,909	(8,632)	208,328	86,800	39,308	(47,492)
Other Contracts (E.g Hoylake Cottage, Claire House etc)	801,053	335,176	314,847	(20,329)	669,660	280,199	263,204	(16,994)	203,355	85,088	79,927	(5,161)	1,674,525	700,653	658,158	(42,495)
c) Prescribing	**24,102,556**	**9,949,535**	**9,880,510**	**(69,025)**	**20,069,955**	**8,284,878**	**7,723,687**	**(561,190)**	**6,095,738**	**2,516,321**	**2,395,482**	**(120,839)**	**50,281,630**	**20,756,257**	**19,999,679**	**(756,578)**
Prescribing	24,102,556	9,949,535	9,880,510	(69,025)	20,069,955	8,284,878	7,723,687	(561,190)	6,095,738	2,516,321	2,395,482	(120,839)	50,281,630	20,756,257	19,999,679	(756,578)
d) Commissioned Out Of Hospital	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
e) Intermediate, Social Care & Reablement	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
f) Other Commissioning Expenditure	**2,241,511**	**861,794**	**691,794**	**(170,001)**	**6,315,561**	**1,466,586**	**1,625,630**	**159,044**	**1,033,899**	**221,423**	**160,509**	**(60,914)**	**9,591,458**	**2,550,007**	**2,478,029**	**(71,978)**
Consortia Commissioning Fund	62,302	28,155	0	(28,155)	29,887	12,450	10,445	(2,005)	763,351	108,699	75,474	(33,225)	855,540	149,304	85,919	(63,385)
Service Development Budgets	566,333	213,117	140,693	(72,424)	1,066,942	535,998	535,998	0	53,559	22,313	22,293	(20)	1,686,834	771,428	698,984	(72,444)
Locally Commissioned Services	854,762	356,146	327,050	(29,097)	714,559	297,729	458,778	161,049	216,989	90,411	62,742	(27,669)	1,786,797	744,490	848,666	104,176
PBC Savings	758,114	264,376	224,051	(40,325)	4,504,173	620,409	620,409	0	0	0	0	0	5,262,287	884,785	844,460	(40,325)
g) Reserves	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
h) Cost Improvement Programme - unallocated	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0**	**0**
Total Commissioning Budget 12/13	**155,514,242**	**63,828,957**	**66,674,778**	**2,845,821**	**134,363,491**	**53,871,502**	**53,685,435**	**(186,066)**	**40,063,693**	**16,234,060**	**16,258,398**	**24,338**	**330,027,939**	**133,970,006**	**136,631,308**	**2,661,302**
Running Costs																
i) Core team Costs	377,656	157,345	156,213	(1,132)	379,118	151,900	116,210	(35,690)	136,762	56,970	54,730	(2,240)	893,536	366,215	327,153	(39,062)
j) Clinical Backfill	430,872	179,530	105,594	(73,936)	329,093	143,266	66,197	(77,069)	125,694	52,375	26,519	(25,856)	885,659	375,171	198,310	(176,861)
Total Running Cost Budget 12/13	**808,528**	**336,875**	**261,807**	**(75,068)**	**708,211**	**295,166**	**182,407**	**(112,759)**	**262,456**	**109,345**	**81,249**	**(28,096)**	**1,779,195**	**741,386**	**525,463**	**(215,923)**
Grand Total	**156,322,770**	**64,165,832**	**66,936,585**	**2,770,753**	**135,071,702**	**54,166,668**	**53,867,842**	**(298,825)**	**40,326,149**	**16,343,405**	**16,339,647**	**(3,758)**	**331,807,134**	**134,711,392**	**137,156,771**	**2,445,379**

Wirral Clinical Commissioning Group

SUI COVER SHEET

Agenda Item:	3.3	**Reference:**	GB12/13052
Report to:	Governing Body	**Meeting Date:**	
Lead Officer:	Lorna Quigley Chief Operating Officer		
Contributors:			
Governance:	**Link to Commissioning Strategy**		
	Link to current governing body Objectives		
Summary:	Quality data and serious incidents relating to providers is regularly reported through the Quality, Performance and Finance committee. The purpose of the attached report is to inform the board of the number of Serious incidents that have been reported through the Strategic Executive Information System (STEIS) for quarter 1.		
Recommendation:	**To Approve**		
	To Note		x
	Comments	Members are requested to: • Note the content of the paper	
Next Steps:			

*This section is an assessment of the **impact** of the proposal/item. As such, it identifies the significant risks, issues and exceptions against the identified areas. Each area must contain sufficient (written in full sentences) but succinct information to allow the Board to make informed decisions. It should also make reference to the impact on the proposal/item if the Board rejects the recommended decision.*

What are the implications for the following (please state if not applicable):	
Financial	To ensure that the CCG Commissions high quality health care that is vlaue for money.
Value For Money	The CCG does not pay for any never events.
Risk	Any risks to the CCG to be recorded on the risk register
Legal	
Workforce	
Equality & Human Rights	
Patient and Public Involvement (PPI)	
Partnership Working	Working with all providers and the CSU to manage the processes
Performance Indicators	
Do you agree that this document can be published on the website? *(If not, please note that it may still be subject to disclosure under Freedom of Information - Freedom of Information Exemptions*	✔

This section gives details not only of where the actual paper has previously been submitted and what the outcome was but also of its development path ie. other papers that are directly related to the current paper under discussion.

Report History/Development Path				
Report Name	**Reference**	**Submitted to**	**Date**	**Brief Summary of Outcome**
Title of Report	Agenda Ref	Title of Meeting	Date	Detail of outcome and next step

Private Business

The Board may exclude the public from a meeting whenever publicity (on the item under discussion) would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution. If this applied, items must be submitted to the private business section of the Board (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The definition of “prejudicial” is where the information is of a type the publication of which may be inappropriate or damaging to an identifiable person or organisation or otherwise contrary to the public interest or which relates to the provision of legal advice (for example clinical care information or employment details of an identifiable individual or commercially confidential information relating to a private sector organisation).

If a report is deemed to be for private business, please note that the tick in the box, indicating whether it can be published on the website, must be changed to a x.

If you require any additional information please contact the Lead Director/Officer.

SERIOUS INCIDENTS SUMMARY REPORT
(Quarter 1)

Introduction

1. A Serious Incident is defined as an unexpected, untoward event in which a person (whether a patient, staff member or visitor) suffered serious harm or could have been seriously harmed or one which is likely to give rise to serious public concern or major criticism of the service involved.

2. A Serious Incident requires a provider organisation to undertake a root cause analysis within 45 working days of the incident occurring, develop a remedial action plan and provide on-going evidence of implementation of the action plan. This process is currently managed through the Wirral Clinical Commissioning Group Quality, Performance and Finance meeting which is held on a monthly basis.

Report

3. Within the period of 1st April 2012 –30th June 2012 Wirral had **8** new incidents reported on the Strategic Executive Information System (StEIS) being investigated and performance managed.

4. The table below details the serious incidents reported for quarter 1

Reporting Organisation	Incident Type	Number
Clatterbridge Cancer Care NHS Foundation Trust	Drug Incident (General)	1
TOTAL		**1**
Cheshire and Wirral Partnership NHS Foundation Trust – Wirral	Unexpected Death of Community Patient (in receipt)	1
	Unexpected Death (general)	4
	Slips / Trips / Falls	1
TOTAL		**6**
Wirral University Teaching Hospital NHS Foundation Trust	Nil Reported	
Spire	Unexpected death	1
TOTAL		**1**
GRAND TOTAL		**8**

Never Events

5. The National Patient Safety Agency has identified some incidents which are described as Never Events. These are largely preventable events which if all the appropriate procedures are followed should not occur. The list of Never Events that are included in the 2011-2012 NHS standard contracts are:

a) Wrong site surgery
b) Wrong implant/prosthesis
c) Retained foreign object post-operation
d) Wrongly prepared high-risk injectable medication
e) Maladministration of potassium-containing solutions
f) Wrong route administration of chemotherapy
g) Wrong route administration of oral/enteral treatment
h) Intravenous administration of epidural medication
i) Maladministration of Insulin
j) Overdose of midazolam during conscious sedation
k) Opioid overdose of an opioid-naïve patient
l) Inappropriate administration of daily oral methotrexate
m) Suicide using non-collapsible rails
n) Escape of a transferred prisoner
o) Falls from unrestricted windows
p) Entrapment in bedrails
q) Transfusion of ABO-incompatible blood components
r) Transplantation of ABO or HLA-incompatible Organs
s) Misplaced naso- or oro-gastric tubes
t) Wrong gas administered
u) Failure to monitor and respond to oxygen saturation
v) Air embolism
w) Misidentification of patients
x) Severe scalding of patients
y) Maternal death due to post-partum haemorrhage after elective Caesarean section

6. In the standard contracts with local NHS care providers there is a requirement to eliminate Never Events. There is a financial consequence for providers if they fail to comply with this requirement.

Recommendations

7. The board is asked to note the contents of this report.

Lorna Quigley
Chief Operating Offcier

Wirral GP Commissioning Consortium

NHS
Wirral Clinical Commissioning Group

WIRRAL GP COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Tuesday 14th August 2012, 7pm
Nightingale Room, Old Market House

Present:

Dr Navaid Alam	(NA)	GP Lead
Dr Akhtar Ali	(AA)	GP Lead
John Callcott	(JC)	Non Executive Advisor
Christine Campbell	(CC)	Chief Officer (Acting)
Chandra Dodgson	(CD)	Finance Lead
Fiona Johnstone	(FJ)	Director of Public Health
Dr Denyse Kershaw	(DK)	GP Lead
Dr Andy Lee	(AL)	GP Lead
Dr Hannah McKay	(HM)	GP Lead
Dr Abhi Mantgani	(AM)	Accountable Officer – Wirral CCG
Ann Riley	(AR)	Nurse Member
Dr Pankaj Srivastava	(PS)	GP Lead

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WGPCC/EB/ 12-13/0024	**1.1 Apologies for absence** Apologies were received from Graham Hodkinson, Karen Hornby, Dr John Oates and Eddy Shallcross.
WGPCC/EB/ 12-13/0025	**1.2 Declarations of interest** No declarations of interest were made.
WGPCC/EB/ 12-13/0026	**1.3 Public Comments/Questions** There was one member of the public present. No comments or questions were raised.
WGPCC/EB/ 12-13/0027	**1.4 Minutes from the last meeting** The minutes from the last meeting were agreed to be a true record of the meeting. <u>Matters Arising</u> Social Care Fund – it was clarified that the total that the Board was asked to approve to be allocated to the Social Care Fund was £330,000 (the figure had been incorrect in the previous month's Board paper); the Board was happy to approve this. Approvals Committee – Several of the schemes approved at previous Board meetings had resource implications for general practice. It had been agreed by the CCG Governing Body Board that any such schemes would be subject to a further Approvals Committee, in order to provide assurance that the schemes were in addition to contractual requirements of general practice, and that they presented good value for money. So, whilst schemes such as the Minor Injury and Illness Service and Community Minor Surgery service had been approved in principle by this Board, they would require further review by the Approvals Committee prior to the final decision being made. Any practices that had previously been told that their bids under these

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	schemes had been successful have since been informed of this further process, and that any decision made initially is now subject to Approvals Committee ratification. <u>Action Points</u> All action points have been completed and may be removed.
WGPCC/EB/ 12-13/0028	**1.5 Complaints and Incidents** CC presented a draft template for reporting trends with regard to the interface forms submitted to the Consortium. The Board was happy with this template, but requested that 'cancelled surgery' was added as an additional field. DK requested clarification on when consultant to consultant referral is and is not acceptable. AM agreed that the guidance on this for practices could be clearer, and it was agreed that new guidance would be circulated along with the new interface form that is being developed. **Action** – The interface form reporting template will be amended and populated in time for next Board meeting. Guidance on consultant to consultant referral will be issued to practices. It was agreed that only complaints pertinent to this Consortium would be brought to this Board. Details of any complaints received since the previous meeting would be brought to each Board meeting, with details of actions undertaken and any issues highlighted. AM explained that the format of the Board meeting will change in order to incorporate more activity relating to Consortium practices, so that the Board members have a more complete understanding of performance. This will include latest referral data, to include practice referrals, and specialties where referrals are highest. CC explained that the latest available referral data shows that a number of practices are making significantly more referrals in comparison to previous months, and this point in 2011. It was proposed that a team comprising CC, Dr Oates, and representatives from the information team would visit these practices to determine if any support could be offered. The Board was happy with this approach, and with more activity data being reported at this meeting. **Action** – referral activity to be reported on a monthly basis to the Executive Board.
WGPCC/EB/ 12-13/0029	**1.6 Minutes for Noting** The Patient Council Executive Board had met on the 9th August and as such the minutes were not available at the time of distributing papers for this Board. A summary of this meeting is given in item 4.2 The Governing Body had met on the 9th August and as such the minutes were not available at the time of distributing papers for this Board. AM gave the following update on the CCG: - the CCG has elected to employ a service redesign function inhouse, rather than purchase this from the Commissioning Support Service (CSS), in order to have greater control over this area of work, and to ensure greater value for money. A structure of QIPP teams will sit beneath a new Clinical Strategy Group which, under the leadership of the Accountable Officer, will be responsible for setting the service redesign agenda across a range of clinical areas. Each division has nominated GPs to chair these QIPP team meetings, and each divisional Chair will chair the CSG on an alternating four-monthly basis. The QIPP teams will be supported by project management and administrative staff to ensure the timely and thorough delivery of workstreams. - AM explained that, following an open recruitment process, a panel had appointed Mark Bakewell as Chief Financial Officer Designate. Mark has been an enormous asset to the

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	Consortium and subsequently the CCG, and has also been through the National Assessment Centre process. The CCG will greatly benefit from Mark's experience and expertise moving forward. - Interviews for the Lay members of the CCG Board were due to take place that week - CC updated that various schemes in relation to alcohol support had been approved by the CCG governing body, including purchase of additional detox and rehabilitation, a pilot of community alcohol support workers, and a local enhanced service to support practices to manage patients with alcohol misuse problems in primary care. This will be subject to the Approvals Committee prior to launch to general practice. - A session on developing the Mission, Vision and Values of the CCG had been held that day. The draft mission and vision will now be shared with stakeholders for feedback and input, in order that this is a jointly produced piece of work.
WGPCC/EB/ 12-13/0030	**2.1 Progress Against Operational Commissioning Plan** CC explained that the operational commissioning plan had been written at a time when the Consortium team were not aware of the resources that would be available in 2012/13. Given the significant resource available, and the Wirral-wide projects that will commence under the QIPP team structure, it is timely to refresh the commissioning plan. This will take place over the coming months. There are various schemes that the Consortium team is exploring, such as improved access to community pain services, IV Iron and a DVT service in the community, along with a number of projects in relation to mental health and dementia. A shared care scheme for dementia is currently being developed in line with the launch of the new pathway from the Memory Assessment Service in the Autumn. The dermatology workstream has been delayed slightly due to an issue with the development of the App on the phone device (it was clarified that this is the fault of the phone manufacturer as opposed to the service provider). AM thanked Carol Diamond and DK for all of their hard work on bringing this project to fruition. Practices should be advised that they can still practise using the devices, even though the App is not available. AA asked for clarification on what happens should a practice not wish to deliver a Local Enhanced Service. AM explained that the Consortium has the right to ask another Member Practice to deliver this service on behalf of that practice's patients. With regard to the Dementia scheme, the Memory Service will need to be advised that some practices may not sign up to the scheme and so it will need to be clear what happens to these patients.
WGPCC/EB/ 12-13/0031	**2.2 Divisional Support for CCG Chair** It was explained that the CCG Chair must demonstrate that he has the full support of the CCG divisions, as part of the Authorisation process. CC had drafted a letter to be sent from Dr Oates on behalf of this Board; those members present were happy to support this letter, and support for Interim CCG Chair, Dr Jennings, was reiterated.
WGPCC/EB/ 12-13/0032	**2.3 Use of Commissioning Resources** CC explained that the Consortium had two sources of resource available: the pooled efficiency savings from 2011/12, and the non-recurrent investment fund devolved to the divisions by the CCG. It was clarified that there was an error in the paperwork, and that there is only £252,000 remaining from the CCG fund. This leaves a total of £410,403 yet to be allocated against schemes. It is crucial that this money is spent in-year, on a non-recurrent basis, on schemes that will bring real value to our patients. The next Clinical Leads' meeting in early September will be used to do a stock-take on current expenditure, and generate further ideas on use of this resource. It must also be noted that whilst significant resource has been allocated to schemes, it is vital that projects are seen all the way through to completion in order that the money is actually spent.

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	In addition to the central resource, funds have also been devolved down to general practice level. It was proposed that a monthly report is brought to this Board detailing the progress of this expenditure. DK commented that practices are finding it hard to keep track of the different sums of money available. AM sympathised with this, and suggested that in future all available funds could be put into a single fund per practice, to simplify the application process. It was also suggested that a presentation on the use of the central CCG allocation is given at the next Board meeting, and the offer will be made to the other divisions as well. This was welcomed. CC and AM thanked the clinical leads and project managers for all of their hard work to date. **Action:** report on Consortium and practice use of resources to come to each Board meeting **Action:** presentation on CCG resource to come to the next Board meeting
WGPCC/EB/ 12-13/0034	**4. Financial Budget 2012/13** CD circulated a paper that contained the latest available Consortium budget position. Apologies were made for the tabling of this paper, but it was explained that the latest position had only become available that week. The Consortium is currently underspent by £39,000 as at Month 4.  WGPCC Finance M4 Full detail is available within the report: A more detailed, practice-level report will be issued later in the week. Members were again encouraged to spend resources as there is no guarantee that they will be available next year.
WGPCC/EB/ 12-13/0035	**4.2 Patient Council and Engagement Update** Apologies had been received from Eddy Shallcross and so CC presented this item. Members noted the content of the report. AM added that the Patient Council and the Consortium's approach to engagement had been shortlisted for a Vision award by the National Association of Primary Care. This is a fantastic achievement and demonstrates the huge commitment made by the Council and the Consortium team.
WGPCC/EB/ 12-13/0036	**4.3 Public Health Update** FJ advised that it may not always be possible for her to attend future meetings, but that she will endeavour to provide a written update wherever possible. The transition of Public Health to the Local Authority is going well. One of the issues still to be addressed is the commissioning responsibility of Local Enhanced Services, where the budgets sit with Public Health, but the schemes themselves are currently commissioned through the Primary care Team. Public Health remains committed to these schemes, such as the Vascular Checks, and the Flu Immunisation schemes, but the commissioning mechanics will need to be worked through. GPs will be involved in this process, and in the development of future schemes, as much as possible. The procurement for Integrated Sexual Health services is underway. It was clarified that any provider can bid to provide any part of the pathway, and it will be the responsibility of Public Health to ensure that the pathway is integrated. There will be a formal meeting of the Health and Wellbeing Board held in September. Discussions will be ongoing around joint commissioning, and how this Board, and the Board of

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	the CCG and its divisions, will work together. It will be vital that the mission, vision and values are aligned. FJ explained that her Deputy Director, Teresa Owen, will be leaving to take up another post in Wales. FJ acknowledged Teresa's invaluable input to date and explained that she will be extremely missed. AM echoed this, and thanked Teresa on behalf of the Board for her significant contribution made whilst with NHS Wirral. FJ explained that the post may not be filled until early 2013, and so the Public Health team may be under-resourced until that point.
WGPCC/EB/ 12-13/0037	**4.4 Practice Nurse Update** AR explained that a meeting had been arranged for Nurse Prescribers in conjunction with Medicines Management, as this is a group that currently does not have the opportunity to meet. Work is ongoing with the Practice Manager leads to develop a schedule of training for Member Practices. The next meeting of the Nurse Forum will be held in September. AR has met with the Nurse Leads from the other two divisions which has been extremely useful in sharing ideas and good practice, and will lead to better Wirral-wide working.
WGPCC/EB/ 12-13/0038	**4.5 Practice Manager Update** No Practice Manager Leads were in attendance. However, CC explained that she had attended the last Forum meeting to provide an update on the latest enhanced services available. Practices had asked for a definitive list of all new schemes, which the Consortium will provide. **Action:** CC to provide a list of all enhanced services to Member Practices.
WGPCC/EB/ 12-13/0039	**4.6 Social Services / Local Authority Update** No representative from Social Services was available. However, FJ explained that a new Chief Executive of Wirral Council had been appointed. He was previously Chief Executive of Blackburn with Darwen, which was named Council of the Year in 2011. He will be joining us in September and will be keen to meet the CCG and divisions early in this role.
WGPCC/EB/ 12-13/0040	**4.7 Items for the Risk Register** It was agreed that 111 would be removed from the divisional register as it is held centrally on the CCG Risk Register. There were no further items to be added to the Risk Register.
WGPCC/EB/ 12-13/0041	**5. Summary of Actions** CC read through the actions of the meeting, which are included on a separate report to be issued with the minutes.
WGPCC/EB/ 12-13/0042	**6. Summary of Financial Approvals** No financial approvals had been made.
WGPCC/EB/ 12-13/0043	**7. Any Other Business** AM had met with Walton Neurocentre with a view to providing additional capacity to pain clinics in the community. Following on from the successful community neurology service, Walton are extremely keen to be involved in this project. This will be a pilot for our Consortium, and may be rolled out Wirral-wide if successful. Its launch will be supported by an educational event. AL raised that the neurology service referral form is very complicated and is sent back to GPs if

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	incomplete. AM explained that others had raised this issue and that it had been flagged with the Clinical Director already. It will be raised again on behalf of the Board. **Action:** Raise issue regarding referral form with Walton Neurocentre. AM explained that a new drug, Dabigatran, was a potential risk to prescribing budgets. This is recommended by NICE as an alternative to Warfarin, but has a high element of clinical risk and also is significantly more expensive than alternatives. It has not yet been approved by the Drugs and Therapeutics Committee. Other neighbouring CCGs have taken the decision not to allow use of this drug. However, our CCG does not wish to deviate from NICE guidance on this matter. A proposal has come to the CCG that anyone wishing to initiate this drug must be able to demonstrate that the patient meets a set of very strict criteria. If initiated in primary care, this must be done with prior authorisation of the Heart Centre GPSIs or the Medicines Management Team. Although this adds an additional step to the process, this is vital in light of the clinical risks involved and the risk of the cost pressure to the CCG. Following discussion it was agreed that this was the correct approach, as long as this is launched properly to GP Members, that the policy is consistently followed by secondary care colleagues, that any initiation in secondary care is done so by a Consultant, and that there is a consistent policy across Wirral. It was suggested that the arrangement could be reviewed in six months' time and the authorisation step removed if there were found to be no problems. The members agreed to this approach.
	8. Private Business There was no private business discussed.
	9. Date and Time of Next Meeting The date and time of the next meeting is Tuesday 18th September 2012, 7.00pm in the Nightingale Room, Old Market House, Birkenhead. Please send any apologies to Anita Fletcher on anita.fletcher@wirral.nhs.uk

The meeting finished at 8.40pm

Wirral Clinical Commissioning Group

WIRRAL HEALTH COMMISSIONING CONSORTIUM
EXECUTIVE COMMITTEE
Minutes of Meeting

Wednesday 9th August 2012
Albert Lodge - Victoria Central Health Centre

Present:	Dr Pete Naylor (Chair)	Chair
	Dr Paula Cowan	GP Executive Lead
	Dr Murray Freeman	GP Executive Lead
	Dr Sean Magennis	GP Executive Lead
	Dr Sue Wells	GP Executive Lead
	Mrs Louise Morris	Finance Lead
	Mrs Carol Heath	Practice Nurse Representative
	Mrs Anita Swift	Practice Manager Representative
	Mr Geoffrey Prince	Patient Forum Representative
	Mrs Teresa Owen	Head of Public Health
	Mrs Angela Carter	Patient Forum Representative

In Attendance:

Mrs Laura Thompson	Commissioning Support Manager
Miss Grace Price-Jones	Executive Assistant
One member of the public	

Ref No	Minute
WHCC/EB/ 12-13/0017	**1.1 Apologies for Absence** Apologies were received from Andrew Cooper, Dr David Jones, Mr Graham Hodkinson, Dr Shyamal Mukherjee and Councillor Phil Davies.
WHCC/EB/ 12-13/0018	**1.2 Declarations of Interest** Declarations of interest were made for all GP's in attendance in relation to potential Local Enhanced Services being discussed within the meeting. The Chair took the decision to continue the discussion with all members present.
WHCC/EB/ 12-13/0019	**1.3 Public Comments/Questions** Three members of the public were welcomed to the meeting. No comments were made.
WHCC/EB/ 12-13/0020	**1.4 Minutes from the last meeting** The minutes from the last meeting were reviewed and accepted as an accurate reflection.

Ref No	Minute
	Matters Arising and Action Points No matters were arising. All actions had been completed.
WHCC/EB/ 12-13/0021	**2.1 COPD LES – 'Finding the Missing Millions'** Amendments have been made to the LES following the last meeting. The LES was agreed by the Board.
WHCC/EB/ 12-13/0022	**2.2 Prescribing Incentive Scheme** The scheme has previously been approved by this Board at a remuneration level of £1 per patient. However, following review across Wirral, a remuneration of £2 per patient has been proposed. The board discussed and reviewed this issue and agreed to amend the funding to £2 per patient. The Board requested that it is highlighted to the Governing Body that schemes need to be fully approved before distribution to practices in future. The scheme was approved at board level and will now be presented to the Wirral CCG Approvals Committee for final approval.
WHCC/EB/ 12-13/0023	**3.1 Improving Asthma Outcomes** This scheme offers Practice Nurse Education and Mentorship on how to educate patients on Asthma. It also allows backfill time for Practice Nurses to put together Asthma Management plans for patients. The scheme in total will cost £20,194.50. The admission rates for Asthma are currently very high. There are currently 10,897 patients on the asthma register. Time pressure on Practice Nurses was highlighted as a potential area for concern. The Board agreed that the practices will require reimbursement for the time taken out of practice for the education element. The Board agreed to add onto the scheme an extra £10,000 to fund the additional time to take the nurses out of practice. The paper was agreed in principle.
WHCC/EB/ 12-13/0024	**3.2 Calm and Create Pilot** The Calm and Create Pilot is a course aimed to help people relax and feel good through the experience of art making. The service has received very good feedback from the patients. This service has been started up by the Wirral NHS Community Trust. The cost of the service is £8,400 for a six month pilot. The Board agreed that Inclusion Matters should be made aware of this service available and that the Community Health Workers should add this onto the list of services available for signposting.

Ref No	Minute
	The paper was approved by the Board.
WHCC/EB/ 12-13/0025	**3.3 Falls Pick Up Service** The falls pick up service is a scheme put into place to assist patients at risk of falling. The patients have a falls monitor supplied which sends out a member of Eldercare in the case of the patient falling. The member of staff will come into the patient's home and pick the patient off the floor and put the patient on a chair or back into bed providing there are no injuries. Eldercare will stay with the patient for a short amount of time to make sure they have refreshments available and feel comfortable and safe in their own home. The patient will be given a package of care for up to seven days. There are now 1,500 patients enlisted onto this service. Patients can be referred into this service via GP referral or Adult Social Services. The Board approved the extension of the contract until 30 June 2013.
WHCC/EB/ 12-13/0026	**4.2 Financial Update** The total budget available is £156.5 million based on a fair share approach. Some of the budgets have been assigned to the Governing Body. As at the end of June there is a £1,403k over performance at Wirral University Teaching Hospitals. The overall overspend in relation to NHS Contracts is £1,351k, there is an underperformance in Accident and Emergency attendances and Non PbR but an over performance in Planned care and Non-Electives. There is an overspend in Non NHS Contracts, this may be due to the transfer of patients following the 18 week target waiting list. This overspend values at £164k. There is currently £1.4 million available for investments. The Chair and Chief Officer are going to utilise some of these monies to support practices in reviewing referrals and time for the practices to work together to try and improve the current overspend.
WHCC/EB/ 12-13/0027	**4.3 Items for Risk Log** The current over performance at WUTH and the risk of not spending the £1.4 million was requested to the added onto the Risk Register.
WHCC/EB/ 12-13/0028	**4.4 Risk Register** The register was reviewed. No comments were made.
WHCC/EB/ 12-13/0029	**5.1 Subgroup Minutes for Noting** The minutes from the May meetings of the sub-committees were noted. No comments were received.

Ref No	Minute
WHCC/EB/ 12-13/0030	**6. Summary of Actions** Please refer to action points attached.
WHCC/EB/ 12-13/0031	**7. Summary of Financial Approvals** COPD LES, Prescribing Incentive Scheme, Improving Asthma Outcomes, Calm and Create Pilot and Falls Pick Up Service to be added on the summary of financial approvals.
WHCC/EB/ 12-13/0032	**8. Any Other Business** The patient representative highlighted to the Board that not every practice within the Consortia has a Patient Participation Group (PPG). The Board agreed that as part of QOF all practices need to have PPGs or virtual PPG's. This will be addressed at the Practice Managers Forum and at the Practice Visits. The Board thanked Teresa Owen for all of her hard work whilst working in Public Health for NHS Wirral and offered congratulations on her new role of Director of Public Health, Pembrokeshire.
	Date and Time of Next Meeting The date and time of the next meeting is Wednesday 19th September 2012, 1.00pm at Albert Lodge, Victoria Central Health Centre. Please send any apologies to Mrs Wendy Holmes on wendy.durno@wirral.nhs.uk

Wirral Alliance

NHS
Wirral Clinical Commissioning Group

WIRRAL ALLIANCE COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Thursday 9th August 2012
The Duncan Room, Old Market House

Present:	Iain Stewart	WACC Chief Officer
	Dr Mark Green	St Hilary Brow Group Practice (Chair)
	Dr Gillian Francis	Spital Surgery
	Dr M Salahuddin	Gladstone Medical Centre
	Dr Richard Williams	Riverside Surgery
	Michael Roach	Non-Executive Advisor
In Attendance:		
	Allison Hayes	WACC Executive Assistant
	Paul Wormald	Strategic Information Analyst
	Allan Stewart	Civic Medical Centre

Ref No.	Minute
WACC/EB/ 12-13/0001	**Preliminary Business** **1.1 Apologies for absence** Apologies were received from Dr Bryan Conlan, Dr Helen Downs, Dr Ivan Camphor and Fiona Johnstone.
WACC/EB/ 12-13/0002	**1.2 Declarations of interest** Dr Salahuddin declared his interest with regards to Gladstone Medical Centre's practice proposals.
WACC/EB/ 12-13/0003	**1.3 Public Comments/Questions** A discussion took place regarding the attendance of members of the public at future WACC Board meetings and it was agreed by members to review this again in 6 months' time. It was agreed that an open day for the public is held twice a year and WACC Management Team will arrange this. ***Action*** – WACC Management Team to arrange open days.
WACC/EB/ 12-13/0004	**1.4 Minutes and Action Points of Previous Meeting/Matters Arising** The minutes from the previous meeting held on 28th June 2012 were agreed to a true record of the meeting and were proposed by Dr Williams and seconded by Dr Francis. **Action Points** – Please see action point summary attached. ***CWG Recommendations*** - Members were provided with an update around AQP.

Ref No.	Minute
	Items for Discussion
WACC/EB/ 12-13/0005	**2.1 Future Board Meeting Format** Members were asked to consider representation at future meetings.
WACC/EB/ 12-13/0006	**2.2 Provision of Phlebotomy Service** Members were asked to consider whether they required more input from the Phlebotomy service. Members asked for more information around how many sessions each practice has been allocated with regarding the fair share of the service. Members agreed that a review of the service is required and that a practice based service is implemented rather that an centralised one**.**
	Items for Approval
WACC/EB/ 12-13/0007	**3.1 The Orchard Surgery Practice Proposal** Members were provided with an overview of the proposals for a Wheelchair, a 24 hour Ambulatory BP Monitor and a Patient Self-Management/Hypertension AF Scheme and were asked to consider the contents. Board members approved the proposals.
WACC/EB/ 12-13/0008	**3.2 Gladstone Medical Centre Practice Proposal** Members were provided with an overview of the proposal for a Medication Review Service and were asked to consider the contents. Board members approved the proposal. Dr Francis proposed all proposals. Dr Salahuddin seconded the proposals from The Orchard Surgery and Dr Richards seconded the proposal from Gladstone Medical Centre.
WACC/EB/ 12-13/0009	**3.3 Management Team Structure Proposal** Members were asked to consider the contents of a proposal regarding a new management team structure, presented by WACC CO. All Board members agreed to the proposal.
WACC/EB/ 12-13/0010	**3.4 Alliance Investment Plan** Members were updated with information regarding the WACC future investment plans and were asked to consider the proposed work streams and give direction on prioritisation and approval. Members suggested concentrating and focusing on areas that had not already been reviewed earlier and WACC management team are to move forward with suggested areas.
WACC/EB/ 12-13/0011	**3.5 GP Locum Schedule** Members were asked to consider a proposal to employ a GP Locum and were asked to approve the proposal to utilise the GP Locum support post to provide cover for GP Board members attending the main providers' contract meetings.
	Items for Information
WACC/EB/ 12-13/0012	**4.1 Quality, Performance and Finance** Members were asked to review and consider the contents of the current finance report circulated prior to the meeting and the data provided by the information team.
WACC/EB/ 12-13/0013	**4.2 Risk Register**

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	Members discussed the contents of the risk register.
WACC/EB/ 12-13/0014	**5.0 Subcommittees minutes for noting** The minutes from the subcommittees meetings were noted.
WACC/EB/ 12-13/0015	**6.0 Summary of Actions** Please refer to action points attached.
WACC/EB/ 12-13/0016	**7.0 Any other Business** Members were asked to consider attending a number of interviews as WACC representatives for the role of Lay Representative regarding the Governing Body Board. ***Action*** - AJH to obtain dates and inform Board Members**.**
	Private Business
	8.0 Date and Time of Next Meeting The date and time of the next meeting is ***Thursday 6th September 2012, 3pm at Civic Medical Centre, Civic Way, Bebington, Wirral CH63 7RX*** Please send any apologies to Allison Hayes on allison.hayes@wirral.nhs.uk

Wirral Clinical Commissioning Group

WIRRAL ALLIANCE COMMISSIONING CONSORTIUM
EXECUTIVE BOARD MEETING
Minutes of Meeting

Thursday 6th September 2012
Civic Medical Centre, Bebington

Present:	Iain Stewart	WACC Chief Officer
	Dr Mark Green	St Hilary Brow Group Practice (Chair)
	Dr Bryan Conlan	The Orchard Surgery
	Dr Helen Downs	Civic Medical Centre
	Dr M Salahuddin	Gladstone Medical Centre
	Dr Richard Williams	Riverside Surgery
	Dr Ivan Camphor	Heatherlands Medical Centre
	Michael Roach	Non-Executive Advisor

In Attendance:

Allison Hayes	WACC Executive Assistant
Paul Wormald	Strategic Information Analyst
Allan Stewart	Civic Medical Centre (Practice Manager)
Dr James Kingsland	St Hilary Brow Group Practice

Ref No.	Minute
WACC/EB/ 12-13/0017	**Preliminary Business** **1.1 Apologies for absence** Apologies were received from Dr Gillian Francis and Fiona Johnstone.
	1.2 Declarations of interest Dr Camphor declared his interest with regards to Heatherlands Medical Centre's practice proposal. Dr Mark Green declared his interest with regards to St Hilary Brow's practice proposal. **1.3 Minutes and Action Points of Previous Meeting/Matters Arising** The minutes from the previous meeting held on 8th August 2012 were agreed to a true record of the meeting and were proposed by Dr Salahuddin and seconded by Dr Williams. **Action Points** – Please see action point summary attached. **1.4 Chair Report** WACC Chair provided a group with an update regarding the developments of the Wirral Clinical Commissioning Group and the initiatives and investments currently being implemented and discussed. Members briefly discussed the Memory Assessment LES and also the Improvements Grant Scheme. Members requested that information is sought regarding the number of bids that were applied for, how many bids were approved and the total overall spend on bids accepted. WACC Chair requested the groups thoughts around 'earned autonomy' and 'dissolved

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	responsibilities' and a discussion took place around these. WACC Chair sought approval from members with regards to holding an away day to look at referrals and how to improve them. Members agreed to hold a PLT session to look at how to better manage referrals.
WACC/EB/ 12-13/0018	**Items for Discussion** **2.1 Envisage Coda - NUMED** WACC Practice Manager representative gave an update regarding the service and provided members with information around the implementation of the service.
WACC/EB/ 12-13/0019	**Items for Approval** **3.1 Heatherlands Medical Centre Practice Proposal** Members were provided with an overview of the proposals for a Minor Injuries Service for patients at Heatherlands Medical Centre. WACC Board members approved the proposal providing regular audits are undertaken of the service. **3.2 St Hilary Brow Group Practice** Dr Kingsland gave a presentation to the group regarding an Urgent Care Evaluation. Members agreed the proposal in principal subject to WACC Management Team receiving the completed proposal documentation.
WACC/EB/ 12-13/0020	**Items for Information** **4.1 Quality, Performance and Finance** Members were asked to review and consider the contents of the current finance report circulated prior to the meeting and the data provided by the information team. **4.2 Risk Register** Members discussed the contents of the risk register.
WACC/EB/ 12-13/0021	**5.0 Subcommittees minutes for noting** The minutes from the subcommittees meetings were noted.
	6.0 Summary of Actions Please refer to action points attached.
	7.0 Any other Business Practices were asked to review the Practice Development Scheme. Members agreed for St Hilary Brow Group Practice to produce a proposal for a member of staff to review WACC constituent practices MIS data and to integrate HRG codes.
	Private Business
	8.0 Date and Time of Next Meeting The date and time of the next meeting is ***Thursday 4th October 2012, 3pm at Civic Medical***

Ref No.	Minute
	Centre, Civic Way, Bebington, Wirral CH63 7RX Please send any apologies to Allison Hayes on allison.hayes@wirral.nhs.uk

Wirral Clinical Commissioning Group

Wirral Clinical Commissioning Group
Quality, Performance & Finance Committee
Minutes of Meeting

24th July 2012
Room 539 at Old Market House

Present:	James Kay (JK)	NEA – Vice Chair CWW PCT Cluster
	Phil Jennings (PJ)	Chair- Interim Chair Wirral Clinical Commissioning Group
	Tony Kinsella (TK)	Head of Performance & Intelligence Public Health
	Mark Bakewell (MB)	Interim Chief Finance Officer Wirral Commissioning Group
	Paul Arnold (PA)	Deputy Director of Human Resources, NHS Warrington
	Abhi Mantgani (AM)	Interim Accountable Officer Wirral Clinical Commissioning Group
	Christine Campbell (CC)	Acting Chief Officer Wirral GP Commissioning Consortium
	Lorna Quigley (LQ)	Interim Chief Operating Officer Wirral Clinical Commissioning Group
	Iain Stewart	Chief Officer Wirral Health Alliance
In attendance:	Zerina McCarthy (ZM)	Secretary

Item No.	Agenda Items	Action
QPF12-3/9.1	**Apologies for Absence** Apologies were received from Andrew Cooper, Interim Chief Officer Wirral Health Commissioning Consortium	
QPF12-3/9.2	**Declarations of Interest** Members were invited to register any potential Conflicts of Interest, none were received.	
QPF12-3/9.3	**Minutes and Actions from the Previous Meeting – 19th June 2012** The Minutes from the last meeting were accepted as a true and	

	accurate recording of proceedings. The Committee noted that the majority of actions identified for completion on the action plan for July had been met with the exception of the following; <u>QPF12-13/2.2 Terms of Reference</u> These will be presented at meeting on the 28th August for final approval and sign off.	 **LQ/MB**
QPF12-13/10.1	**Terms of Reference (TORs)** The DRAFT TORs are to be circulated to Members for comments and will then be presented at the next Quality Performance & Finance(QPF) meeting **Action:** LQ to circulate DRAFT TORs for comment and present at the next QPF to sign off. JK advised that the Primary Care Trust (PCT) undertook an annual review on TORs, once all TORs are finalised they should be presented to the Audit Committee **Action:** MB and PJ to continue with the work in progress for all Committee TORs.	 **LQ** **MB/PJ**
QPF12-13/10.2	**Provider Performance** TK asked that the title of this item be amended to 'Performance' **Action:** ZM to amend. 'Other acute provider' paper is in progress, any exceptions will be highlighted. Measurement indicators will become 'live' in year 2013 depending on the Governing Body strategic aims. JK expressed concerns over the number of indicators that were included within the Community Trust paper he considered that these should be down to around 20 indicators. He suggested a drive to identify key indicators in order gain a strategic handle on them. AM shared JK's concerns. The Wirral Clinical Commissioning Group (WCCG) will be held accountable he suggested bringing in other areas as an exception. AM suggested contacting the contract monitoring teams for advice on what the QPF should concentrate on, look at the detail, what to	 **ZM**

	prioritise. This information should be presented at the weekly Operational Team meetings and then any exceptions should be highlighted to the QPF. CC advised that initial stage reporting was taken to the Contract Monitoring meetings and then these if necessary are fed into the QPF. PA questioned that when data was being requested from the provider did it include any data as part of the workforce team? TK advised that there had been a limited request for integrated performance measures (IPM) JK informed the Members that the QPF would have an interest in being informed on areas such as workforce turnover, annual staff survey, complaints. CC suggested that each contract Lead should get together with TK and discuss key performance indicators (KPIs) TK advised that there are National and Statutory requirements and the WCCG was receiving the measures needed to conduct its business. PJ reiterated that this was not 'live' data and he was reluctant to see further reductions at this stage, it was a good start however it was unclear how to incorporate the workforce data. He asked that PA and TK to work together and discuss this further. **Action:** PA and TK to work together and report back to the QPF LQ was particularly interested in the sickness levels regarding Medical staff and the impact in relation to the achievement of waiting time targets. This would test the resilience of the organisations operational plans and the sustainability of the targets. **Action:** PA to agree a set of KPIs which would include Bank and Agency staff and also sickness data. **Action:** TK advised that there were difficulties for his team in obtaining this data, however he will disseminate to the Members when this data is to go live. JK suggested identifying areas that the CT were struggling with regarding data capture and if there was anything that could be done to support regarding IT investment.	**TK/PA** **PA** **TK**

	MB advised that investment had already been provided and the CT had been approached with an offer of support. TK suggested that there may be staffing issues and would short term contract staff help to ease their situation. AM thought it was a combination of the IT infrastructure and staffing issues. **Action:** TK to discuss at the Operational Team meeting. PJ and AM to contact Simon Gilby for an update. <u>Operating Framework Performance Measures</u> TK advised that guidance is produced ongoing throughout the year and all major indicators are delivering a 'RAG status' of Green. <u>Mental Health Report</u> TK advised that this expanded over a number of service providers. A significant amount of work in the last year had been undertaken by his team. He also advised that the WCCG was light years ahead of any other organization, it continues to be in development, no exceptions highlighted and this was pertaining to all providers. CC stated that the information contained within the report would be most useful to the mental health QIPP. **Action:** TK to forward report to the Mental Health QIPP Chair. TK suggested providing the Mental Health, Community Trust and all provider reports on a quarterly basis, however the Chair was reluctant to do this due to the infancy of the WCCG and requested that full reports are continued to be provided to the QPF on a monthly basis. **Action:** TK to provide monthly reports. CC asked if there were any other providers that represent large contracts TK advised there will be exceptions to come across CC asked if there will be a threshold TK advised that these are monitored outside of this meeting MB informed the members that contract stabilisation work was going	**TK/PJ/AM** **TK/PJ/AM**

	on with the top 10 out of 15 contract values. AM expressed his concern regarding the sensitivity and scrutiny with these being presented together as Wirral providers and would prefer them to be listed separately as independent providers. **Action:** MB to identify and produce two separate list of providers. <u>Wirral University Teaching Hospital</u> TK advised that measured against last year the GPs overall was over performing with a trend showing 3, 500 additional referrals for this year. This equates to an over performance of 18%. MB informed the members that achievement against QIPP target were included into the contracts, therefore if there is a continual over performance this will lead to the CCG not achieving QIPP. Work is being undertaken over the coming months to assess the impact of the QIPP schemes on performance. TK advised that this is a priority SHA and they were looking for detailed triangulation against QIPP plans, and performance managing the CCG on this. AM asked was there a threshold on Consultant referrals, TK advised that there is. PJ asked if the bulk increase of activity was due to a handful of practices, initial reports suggest over-performance and half of the budget is already spent and worryingly it is only August. AM advised that there is a £1.4 million overspend and he wanted to know what steps were in place to address this issue. He was assured that the Divisional Chairs were tackling this problem. He proposed for bi-monthly or quarterly Divisional reviews to be undertaken which would highlight this activity. He also suggested practice visits and letters to be sent out. CC wanted clarity and understanding of though areas that have high referrals. **Action:** TK to advise Divisional Chairs on which practices have high referrals. **Action:** All Divisional Chairs to provide Practice Action Plans at the next QPF meeting on the steps that Practices are undertaking to address referrals.	**TK** **MB** **AC/IS/CC**

	Outpatients The report highlighted over performance.5% increase in new and 9% increase in follow up appointments. TK advised that this data is subject to change and performance issues will be discussed at a SHA/ cluster performance meeting on 31st August. MB advised that the data has been difficult to reconcile, due to technical /recording changes had been made within WUTH. LQ agreed that this needed to be highlighted via the contracting monitoring meetings, as this will be difficult to manage demand. TK reiterated that there were particular problems with Outpatients. A&E had been underperforming against plan. Non-effective spells over-performing by 5%, reduce figure by 180 spells. Issues remain around N12 and NZ reconciliation but nothing untoward.	**AM/PJ** **TK** **Divisional Chairs**
QPF12-13/10.3	**Finance** A report was tabled updating the CCG on the current financial performance against budgeted allocation for 2012/13 as at Month 3 (June) 2012. Agenda Item 32.2 - QPF Wirral CCG Finar The Committee noted ➢ the financial position as at the end of June 2012 ➢ the requirement by the CCG to develop, agree and implement	

	spending plans against the non recurring investment where not already approved ➢ the potential risks identified for 2012/13 financial performance	
QPF12-13/11	**Items for Approval** There were no items presented for approval.	
QPF12-12/12	**Items for Information** 12.1 Wirral Investment Plan – Monitoring Template MB presented a report to the Committee a Summary of Investment Proposals for utilisation of Non-Recurrent 'Revenue' resource.  Agenda Item 32.2 - GB Non Recurrent Inv **Action:** On the next report for the QPF, MB was asked to ensure that 'Other Primary Care Premises Improvement followed on as item iii. Alcohol/Detox Investment AM advised that discussions had taken place surrounding detox at home with the Drug and Alcohol team. It was highlighted that 46 patients were the highest attenders to the A&E and they were looking to at a Nurse Practitioner in the Community to be the first point of call. **Action:** Sec to invite Accountable Officer to the next Governance & Audit Working Group meeting 12.2 Contractual Issues The Committee noted the minutes from the CWP Contracting Monitoring Meeting on the 24th May 2012. CC advised that advice was being taken the CWP reports that should be presented at the QPF meetings. She also informed the Committee of the lack of clinical representation on the contract meetings and requested that the Divisional Chairs encourage clinicians to attend. JK asked if the action under 'Item 9 Finance Update' had been completed. CC advised that the action had not yet been completed however she	**MB** **ZM**

	would keep the QPF fully briefed. MB advised that negotiations were being taken with the Liverpool PCT around the 'Royal' site. A sum of monies was being provided to Clatterbridge Cancer Centre to help facilitate this. There are contract issues however this will not directly affect the WCCG. CC advised that the task and finish group set up for the perinatal pathway had been completed it's an objectives with the pathway being signed off. **Action:** AM had received an e-mail from the CWP Chair to which he will respond with input from AC. LQ advised that the last Wirral Hospital meeting had been cancelled due to the BMA day of action. The next meeting will take place on 26th July. She advised the group that due to the serious breach upheld by the regulators Monitor, monthly performance meetings where taking place to give the committee assurance that regular contact was maintained. **Action:** Two sets of Quality Minutes were to be presented to the Governing Body Board meeting. The Committee noted the minutes of the Wirral Community NHS trust Contract Monitoring meeting on the 19th June 2012. 12.3 <u>Quality Update</u> LQ presented the Serious Incident reports to the Committee. She advised that a maternal death had been reported yesterday and Spire Murray Filed hospital had a post-operative death. There had been 16 incidents around the Wirral area, Commissioning Support Services (CSS) were undertaking an investigation on behalf of the WCCG. A formal response has been drafted on behalf of the Chairman. PA asked to which Group should the risks on performance be highlighted, he was advised that currently they should remain the responsibility of the Primary care department. Future responsibility will be directed by the given by the National Commissioning Board. IS asked if 'Root Cause Analysis' is built into the CSS contract offer. LQ advised that it had been. JK advised that a mechanism needed to be implemented to monitor, however LQ advised that the SHA have always monitored but a	**AM** **LQ**

	process will be implemented from April 2013. AM advised that the summary should be presented at the next Governing Body Board meeting on the 7th August but suggested the Chairman seek advice from the organizations solicitors, Hill Dickinson on areas to be conducted as private business. **Action:** Chairman to contact Hill Dickinson for advice. **Action:** Secretary to add Summary Report to the Governing Body Board Agenda on the 7th August 2012. LQ advised there was no patient identifiable information reported. The Committee noted the Serious Incident Report 12.4 <u>Authorisation Update</u> **Action:** LQ is to amend the code for the RAG ratings The Committee noted the GANTT Chart for Authorisation process 12.5 <u>Schedule of Meetings</u> ZM advised the QPF of the schedule of meetings set and the dates for submission of papers. TK expressed concerns over the dates for papers to be submitted. It was decided to undertake further discussions outside of the meeting with the Chairman. **Action:** TK to discuss with Chairman paper submission dates.	**PJ** **ZM** **LQ** **TK/PJ**
QPF12-13/13	**Risk Register** HJ presented to the Committee the Risk Register which had been populated with the one highlighted risk which was around the increase in activity for GPs as a result of the introduction of NHS111. HJ advised that this would be considered the Master template to which all Divisional risks would be populated onto. The Committee noted the Risk Register	
QPF/12-13/14	**Summary of Actions** Summary Actions are as per Annex A	
QPF/12-13/15	**Any Other Business**	

	LQ informed the Committee of a 'discharge' report whereby a Surrey Nursing Home had undertaken a survey. She advised that there were dignity and privacy issues and the survey was unpleasant to read on how patients were discharged. JK however stated that it was a good piece of work from LINK. IS asked if it was a recent piece of work, LQ advised that the survey had been undertaken between the months of January and July 2012. **Action:** PJ requested that the survey report was e-mailed through to him. AM left the meeting at 1515hrs	**LQ**
QPF/13-13/16	**Date of Next Meeting** There being no further business to discuss the meeting closed at 1530hrs. The next Quality, Performance & Finance meeting is scheduled to take place on Tuesday 28th August 2012 at 1300hrs.	

Phil Jennings
Chairman

August 2012

RISK REGISTER - Master

Risk ID	Date	Source	Risk Description	Strategic Objectives (reference to detail)	Impact	Likelihood
1	3.07.2012	Gov Body	Increase in activity for GP's as a result of the introduction of NHS111		3	3
2	Ongoing	CSS	Reduction in local expertise and organisational memory due to PCT staff leaving		2	4
3	24.07.12 / 28.08.12	QPF / WHCC	Overperformance on WUTH Contract	Financial Management	3	4
4	28.08.12	QPF	Inability to monitor CT contract performance / outcome measures due to unavailability of information	Quality / Financial Management on Cost Per Case / Impact on Future Commissioning Intentions	2	4
5						
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16						

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Gov Body
WACC
WGPCC
WHCC
PFQ
G&A
CSG
CSS

Completed
On-going
Outstanding

Impact Values	
Negligible	1
Minor	2
Moderate	3
Major	4
Catastrophic	5

Probability Values	
Rare	1
Unlikely	2
Possible	3
Likely	4
Almost Certain	5

Green/Yellow/Red Threshold Values	
Green - maximum score	4
Yellow - minimum score	5
Yellow - maximum score	12
Red - minimum score	15

Matrix Score	Key Control Established	Key Gaps in Control (reference to evidence)	Assurance on Controls (reference to evidence)
9.00	Current provision of primary care / urgent care services - ability to absord additional activity	Unknown impact of 111 Service Impact	Monitoring of Primary Care/ urgent care activity and performace of NHS111 through information flows
8.00	CSS / CCG Transitional Arrangements, Procedure Notes, CSS SLA, Legacy Documentation, Appropriate Handover	Individuals leaving before handover process is complete	CSS SLA Arrangements ensuring continuity, locality link involved in CSS Operational Group Meetings
12.00	Financial / Activity Reporting through QPF / Gov Body. Divisional Reporting / Practice Level Reviews - Action Plans	Ability to influence contract performance - Implementation of Action Plans	Regular Monitoring through committee / gov body structure, Use of Contigency Funds / Planned Slippage to offset
8.00	CT Contract Monitoring / (Contract Query raised), Refinement of KPI's	Ability to influence provider behaviour	Regular Monitoring through contract monitoring process and subsequenty committee / gov body structure with ability to withold payment for non-provision of information as required
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Gaps in Assurance (reference to evidence)	Action	Owner	Date of next review	Date of last review	Status
Timely impact on monitoring of primary care activity	Monitor Information regarding implemention of 111	Governing Body	As further information becomes available	Jul-12	On-going
SLA still in infancy	Continue development of SLA, transitional arrangements, clarity of responsibilities	Chief Officers	Aug-12	Jul-12	On-going
Ability to influence behaviour	Review performance areas, initiate action plan to address performance issues	Divisions	Sep-12	Aug-12	On-Going
Ability to influence behaviour	Review contract query outcome, monitor action plan,	AC / TK	Sep-12	Aug-12	On-Going

RISK REGISTER - Governing Body (Master)

Risk ID	Date	Source	Risk Description	Strategic Objectives (reference to detail)	Impact	Likelihood	Matrix Score	Key Control Established	Key Gaps in Control (reference to evidence)	Assurance on Controls (reference to evidence)	Gaps in Assurance (reference to evidence)	Action	Owner	Date of next review	Date of last review	Status
1	3.07.2012	Gov Body	Increase in activity for GP's as a result of the introduction of NHS111	To be completed when objectives set	3	3	9.00	Current provision of primary care / urgent care services - ability to absord additional activity	Unknown impact of 111 Service Impact	Monitoring of Primary Care/ urgent care activity and performace of NHS111 through information flows	Timely impact on monitoring of primary care activity	Monitor Information regarding implemention of 111	Governing Body	As further information becomes available	Jul-12	On-going
2							0.00									
3							0.00									
4							0.00									
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Gov Body	Completed
WACC	On-going
WGPCC	Outstanding
WHCC	
PFQ	
G&A	
CSG	
CSS	

Impact Values	
Negligible	1
Minor	2
Moderate	3
Major	4
Catastrophic	5

Probability Values	
Rare	1
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Green/Yellow/Red Threshold Values	
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